Findings
and Recommendations

Funding of Hospital Care

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Legislative Program Review
& Investigations Committee

CONNECTICUT GENERAL ASSEMBLY

Introduction

Funding of Hospital Care

Connecticut has 31 acute care hospitals, and all but one are non-profits, although hospital organizational arrangements vary considerably and many are linked to for-profit entities in their governing structures. Connecticut's hospitals for the most part are facing a worsening financial condition than the rest of the nation. More than 30 percent of Connecticut hospitals have had negative operating margins in six of the last seven years. Six hospitals are in serious financial condition, with negative margins for all of the past three years, or a large negative margin for the last year. There are many contributing factors.

Connecticut, like the rest of the country, has an aging population. Fifteen percent of the state's population is enrolled in Medicare, compared to the national average of 14 percent. The elderly Medicare population together with the state's Medicaid population now account for more than 25 percent of the insured population – up from 22.8 percent just four years ago.

Connecticut spends a lower percentage of its health care dollars on hospital care (30.8 percent) than the rest of the nation (36.6 percent.) At the same time, a much higher percentage of the state's expenditures go to long-term care (12.5 percent), versus 7.5 percent nationally. These expenses mainly go to fund nursing home care for the elderly, but leave fewer dollars to be spent on acute and primary care for the under-65 population.

Further, because long-term care is primarily paid by Medicaid, Connecticut hospitals (and other non-nursing home Medicaid providers) must compete for a smaller share of the state's Medicaid dollars. For FY 04, Connecticut spent $1.016 billion, or one-third of the state's Medicaid budget, on nursing home care. All Medicaid hospital spending including Fee-for-Service, Medicaid Managed Care, and disproportionate share payments totaled about $637 million.

There is a limited opportunity to cost-shift nursing home costs on to private pay patients, since Medicaid pays for about two-thirds of long-term care. Medicaid[1] payments to Connecticut's 31 acute care hospitals account for only about 10 percent of all payments. The payments from public insurers, especially Medicaid, have historically been lower than private payers, with an expectation that the gap would be covered by private insurers. However, as will be discussed in the report, the ability to shift the costs of those underpayments has become more limited, especially for some hospitals that have been seeing their private pay population shrink. At the same time, many Connecticut hospitals have older physical plants compared to hospitals in the rest of the nation, but some do not have adequate cash reserves and are not able to obtain financing for capital improvements.

[1] For purposes of this report, Medicaid payments to hospitals refers, unless otherwise indicated, to all state medical assistance, including Medicaid managed care, fee-for-service and State Administered General Assistance (SAGA) payments.

Federal government actions, including the Balanced Budget Act of 1997, have also had a negative financial impact on most hospitals in the Northeast, including Connecticut, as Medicare readjusted its rate structure to pay more to hospitals in rural areas of the country while maintaining budget neutrality.

In addition to these elements, there has been a convergence of other factors that have negatively impacted a great many hospitals in Connecticut. A primary aspect is the imbalanced health care and hospital market structure. There has been considerable consolidation in the state's health insurance industry. In 1995, Connecticut had 12 licensed health maintenance organizations (HMOs), and five of them were non-profits. Currently, there are six licensed HMOs and all are for-profit. There are about 20 other companies that underwrite health insurance, but the market is dominated by a few insurers. In fact one, company has 43 percent of all individuals covered by private health insurance.

Until 1994, Connecticut had an all-payer rate setting system for hospital payments. Under this regulatory framework, all hospitals were almost assured their costs would be covered by the various government and private payers. Since rate deregulation, however, private insurers negotiate with hospitals on the amount of payments they will be paid, and public payers set rates that hospitals must accept. This deregulation scenario assumed that negotiated hospital payments would bring costs down, but it also assumed that consumers could live with the consequences of competition in health care – a hospital not covered in a network or ultimately a hospital closing.

However, as the report discusses, the health insurance and hospital markets in Connecticut are highly concentrated, with a great percent of market share dominated by a few insurers and a small number of hospitals. The competitive nature of private payment through negotiation has not reined in costs overall, but has driven some hospitals (especially smaller ones) to financial instability.

At the same time, many privately insured and Medicare clients are obtaining their medical services outside of hospital settings, further affecting hospitals' bottom line. The regulatory structures for demonstrating medical service need as well as reporting requirements have historically focused on hospitals, and have not kept pace with the current health care environment. The report recommends broadening and strengthening those requirements to better reflect today's health care system.

Connecticut hospitals are not all similar or equal entities, and a combination of historical, regulatory, and market forces have shaken the financial foundation of many. Further, while there is a community expectation that local hospitals will be there for 24-hours-a-day emergency care and basic medical treatment, it seems clear that for elective procedures or more specialized medical services, patients are going elsewhere. In many cases, the smaller urban and community hospitals have the lowest expenses, but state government cannot dictate where people should go to receive their medical service, and increasingly it is apparent that managed care has not been successful in that either.

Without private paying patients obtaining services at hospitals, it is likely that not all hospitals will survive as currently structured. The recommendations contained in the report

change the Medicaid fee-for-service payment structure, and increase accountability of Medicaid managed care organizations, but Medicaid payments are not a large source of most hospitals' revenue stream. While the recommendation should make that payment system fairer, for the smallest hospitals, serving less than one percent of all patients statewide, and a smaller portion of Medicaid clients, the payment changes from Medicaid will not help their financial situation.

Market forces -- whether inability to compete for scarce nursing and other medical personnel to staff hospitals, or inability to attract enough private paying patients to cover hospital expenses -- may result in further consolidations or closures. However, hospital mergers or closures may not bring about lower hospital costs, but rather only shift utilization to the remaining higher-cost hospitals.

Hospital care and its funding is only one part of the fragmented, partly regulated, partly competitive, multi-payer, costly health care system. Increasingly, economists and health care policy experts indicate that recent growth in health care costs is unsustainable, and that unless actions are taken to curb that growth, they predict dire consequences.

The areas contributing to higher health care costs in Connecticut that need closer examination are numerous, interconnected, and complicated. Many of those cost drivers -- from nursing shortages to Connecticut's high portion of health care expenditures for nursing home care -- are discussed in the report, but are beyond the scope and resources of this hospital funding study. The report recommends a panel be formed to examine and recommend strategies to make private health insurance more affordable and improve access to primary and preventive health care.

Study scope. The primary focus of the study was to examine the mix of revenue sources hospitals rely on to fund services. Specifically, the study was to evaluate the adequacy and equity of hospital rate setting processes, and how government payments impact the financial viability of Connecticut hospitals.

Report Format. The findings and recommendations report contains four chapters. The first chapter discusses Connecticut's hospital payment system by the various payer sources with particular focus on the state's Medicaid rate reimbursement system. Chapter II examines additional financial assistance available to Connecticut acute care hospitals including hardship grants, disproportionate share (DSH) programs, and hospital bed funds. The third chapter provides information on emergency room and Medicaid inpatient utilization. Finally, the need for continued health care cost containment efforts is presented in Chapter IV.

Chapter I

Connecticut's Hospital Payment System

As discussed in the briefing hospitals depend on three major payer groups to fund services:

- Private payers;
- Medicare; and
- Medical Assistance (including Medicaid Managed Care, Medicaid Fee-for-Service and State Administered General Assistance (SAGA)).

In addition there are uncompensated care programs and disproportionate share programs that cover some of the hospital costs for the under- and uninsured. Table I-1 below illustrates several major features of each payer source. Each payer source compensates hospitals in a different way.

Private pay. Private payers negotiate with hospitals on what they will pay; typically these payments are discounts off charges. In FY 02, those discounts averaged 41 percent off charges, by FY 05 the discounts off all charges statewide averaged 53 percent, and the median discount was 43.3 percent. However, hospitals may raise charges at any time so the increase in discounts is not that meaningful. The more meaningful statistic is the percentage of costs covered by private payers. On average, private payers compensate Connecticut hospitals for 120 percent of their costs, and pay all hospitals except St. Mary's and Connecticut Children's Medical Center for at least their costs.

Medicare. Medicare, which is a federal government program, sets payments prospectively for inpatient care and for most outpatient services as well. Medicare has on average paid Connecticut hospitals close to the costs (97%) of providing care to Medicare patients, but 22 hospitals receive Medicare payments that are less than their costs.

Medical Assistance. For hospital payment purposes, all state medical assistance programs are considered together, although in actuality, there are three separate programs -- two under Medicaid and the SAGA program -- for different populations. Medicaid, which is a joint federal and state program, reimburses Connecticut for 50 percent of its medical assistance costs for the three programs. Each state administers and operates its Medicaid program differently, with eligibility and coverage criteria designed by the state in a state Medicaid plan that must be approved by the federal government.

Connecticut operates its Medicaid program in two very different ways:

- Medicaid managed care (MMC) covers families; known as the HUSKY program, clients choose one of four different managed care plans;
- Single, aged or disabled Medicaid clients are in a traditional fee-for-service (FFS) program.

The SAGA program is a program that covers individuals either not eligible for Medicaid, or awaiting eligibility determination. The state receives 50 percent reimbursement for SAGA medical expenses, although the coverage for clients is split. The Department of Social Services pays for SAGA *inpatient hospital medical care* and the Department of Mental Health and Addiction Services pays for SAGA *hospital psychiatric care.* SAGA clients receive other medical care through an arrangement between Community Health Network and local federally qualified health centers.

The two Medicaid programs and the SAGA programs are considered together, and called medical assistance, for hospital payment purposes, and for the analysis in this report, Medicaid and medical assistance are considered the same unless noted otherwise. As the table shows, the medical assistance revenues cover on average only 73 percent of hospital costs and only one hospital is paid fully for costs.

Table I-1. Hospital Funding by Major Payer Source

Program	Enrollees	Hospital Payment Structure	Percent of Total Hospital Revenue	Percent of Costs Covered	Percent of Inpatient stays	Percent of Inpatient Days	% of Revenue Inpatient vs. Outpatient
Medicare	524,000	Prospective Payment System (PPS) for inpatient based on DRGs with certain add-ons including indirect medical education (IME); Outpatient PPS based on ambulatory procedures classification	41%	97%	40%	50%	76.4%
Private Pay (fully covered and self – insured plans)	2,395,459	Negotiate directly with hospitals	53.5%	120%	40%	32%	47.2%
Medicaid Managed Care	300,000	Plans negotiate with hospitals	4.5%	73%	8.5%	9.8%	52%
Medicaid Fee-for-Service	68,000	DSS sets rates based on cost reports and target discharge rates for inpatient; fee schedule or overall ratio of cost to charges for outpatients	4.8%		5.7%	7.2%	64.4%
SAGA	35,000	DSS pays medical portion, DMHAS pays for behavioral health, CHN covers $ other than hospital			2.5%	3.3%	
Uninsured	About 407,000	Uncompensated Care and DSH			2%	1.6%	

Factors influencing hospital financing. Several factors impact hospital funding including: 1) the variety of payer sources, both public and private; 2) the assorted methods in which the payers compensate hospitals; 3) hospital reliance on different payers as a percentage of all revenue; and 4) the differences in payer source utilization. Table I-1 portrays hospital funding elements statewide, but as the briefing report discussed, the metrics vary by individual hospital and the impact each measure (or combination) has on a hospital's financial condition. Much of the variation and impact is beyond the control of state government, because the majority of revenue is from private payers or from the federal government.

The study's focus from the beginning was on the payment structures for which the state has direct responsibility. Thus, program review concentrated its findings and recommendations on Medicaid, SAGA, and uncompensated care and disproportionate share programs and the reimbursement systems covering those programs.

Medicaid Fee-for-Service Inpatient Rate-Setting

There has always been a tension between containing costs in the Medicaid programs operated at the state level, and paying providers sufficiently to assure client access to health care. As noted in the briefing, Connecticut established its inpatient rate setting structure in 1983, adopting the methodology that the federal Medicare program was using at the time, but has since changed.

Connecticut's Medicaid Fee-for-Service program reimburses hospitals for inpatient care using target discharge rates that were based initially on 1982 cost reports, and adjusted for inflation in some years, depending on the state budget. Thus, hospitals with lower costs in that initial year have been disadvantaged, because over time the gap between payments and costs has widened.

In 1995, Connecticut established a managed care approach for its family Medicaid recipients, which essentially privatized the payment structure to medical providers for certain clients (discussed later in this section). DSS maintained the payment authority for the non-family clients under the fee-for-service reimbursement system.

In 2001, DSS was given legislative authority to update hospital target rates for Medicaid fee-for-service payments based on each hospital's 1999 cost report filing (adjusted to 62.5 percent of costs). Hospitals would receive this updated rate if the new target amounts were higher than the old rates with the federal inflation factor (up to 10 percent).

Of the 31 hospitals, 17 received the rebased rate adjustment. But hospitals with lower costs, and especially those that had kept them low from 1982 through 1999, were again penalized for payment purposes. There have been two additional readjustments since that time to raise the minimum target rate – April 1, 2005, it was set at $3,750, and on October 1, 2006, it was raised to $4,000, which adjusted the rate for 18 hospitals. CCMC does not have a target rate since it serves very few Medicaid FFS clients.

Table I-2. Range of Base Medicaid Target Rates Per Discharge	
Effective 10/01/06	**Number of Hospitals**
Minimum rate of $4,000	18
$4,001 to $4,999	6
Over $5,000 to $7,797	6
Total	30
Source of Data: Department of Social Services	

While the range in the rates has narrowed, as the minimum rates have increased over the past two years, the variation in the current target rates is still considerable. The highest target rate at John Dempsey Hospital is $7,797, almost double the new minimum target rate.

Hospitals must file detailed annual cost reports to the Department of Social Services, even though in most years their actual costs are not considered for rate increases. *Connecticut is one of only six states that continue to set inpatient Medicaid payments to hospitals based on costs.* Table I-3 shows how different states set Medicaid rates.

Table I-3. State Medicaid Inpatient Payment Systems	
Payment System	**States Currently Using**
Per-Stay Case-Adjusted Using Medicare Diagnostically Related Groups (DRGs)	24 states -- CA, CO, IA, IL, KS, KY, MI, MN, MT, NC, ND, NE, NH, NJ, NM, OH, OR, PA, SC, SD, TX, UT, WI, WV
Per-Stay Case-Adjusted Using All Patient or Champus (military) DRGS	5 states and DC -- DC, GA, IN, NY, VA, WA
Per Stay – Other	4 states -- DE, MA, NV, WY
Per Diem	10 states -- AK, AZ, FL, HI, LA, MO, MS*, OK, TN, VT *Moving to APR-DRGs 7/01/07
Cost-Based Reimbursement	6 states -- AL, AR, CT, ID, ME, RI
Regulated Charges Based on All Patient Refined APR (newer grouping system) DRGs	1 state -- MD

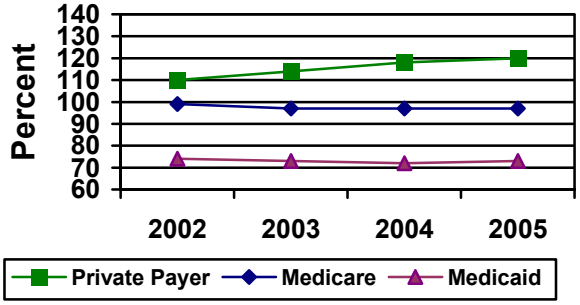
Medical assistance payment shortfall. Medicaid (i.e., all state medical assistance revenue) under-funding of hospital costs is an issue nationwide. Program review examined the payment to cost ratios for the three major payers from 2003 to 2005, and compared that to the same ratios nationwide. The results are these are shown in Figures I-1 and I-2.

As the figures show, nationally, Medicaid pays a greater percentage of hospital costs than the program pays in Connecticut. Nationwide, Medicaid paid about 87 percent of hospital costs, while in Connecticut, the Medicaid program reimbursed hospitals for about 73 percent of their costs.

Medicare, on the other hand, reimbursed hospitals in Connecticut for about 97 percent of hospital costs, while nationally the average was about 92 percent. For the rest of the country,

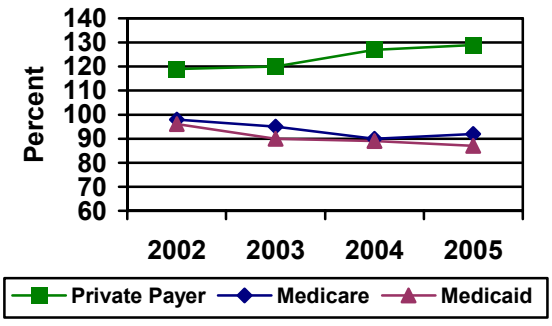
though, there has been a greater cost shift to private payers (in terms of percentages) than in Connecticut. Nationally, the ratio for private payers has increased from 120 percent of costs in 2002 to about 130 percent in 2005. In other words, private payments are about 30 percent higher than costs nationally; in Connecticut the percentage has climbed from about 110 percent in 2002 to 120 percent in 2005.

Figure I-1. Payment to Cost Ratios: Connecticut



Source: OHCA

Figure I-2. Payment to Cost Ratios: Nationally



Source: AHA Issue Brief

However, the ratios should not be looked at in isolation. First, Medicare is a much bigger payer source than Medicaid in Connecticut, and the rest of the country. In Connecticut, about 41 percent of hospital payments are from Medicare while slightly less than 10 percent are from Medicaid. Nationwide, Medicare averages about 39 percent of all hospital payments, while Medicaid averages about 14.5 percent. The fact that Medicare reimburses Connecticut hospitals closer to costs overall means there is less of a gap from that government program to fill here.

Connecticut also has a lower percentage of uninsured than the national average (slightly less than 12 percent versus 16 percent nationally). Thus, the financial burden on hospitals of providing care to the totally uninsured should be less here. (Programs that address the uninsured are discussed in greater detail later in this section).

While the percentage over costs that private payers in Connecticut contribute to hospitals is less than nationally, without knowing the costs in each case, the actual financial burden on private payers is difficult to gauge. As noted in the briefing, Connecticut's inpatient hospital costs are about 15 percent higher than the national average; therefore in actual dollars, the burden on private payers is probably greater in Connecticut. *However, because the gap in government payments (especially Medicaid) has not been shifted to private payers in Connecticut to the extent it has nationally has most likely been a contributing factor to the tenuous financial condition of some Connecticut hospitals.*

It became clear during this study that analyzing statewide hospital funding in the aggregate is problematic since each hospital's geographic location, service component, payer mix, and financial and utilization metrics are different, and reporting a state average or median masks the impact of any of these elements on any one hospital. Thus, a more in-depth analysis

of the state Medical Assistance payment structure and its impact on individual hospitals is provided below.

Impact of Medical Assistance Underpayment Among Connecticut Hospitals

Medical Assistance underpayments to Connecticut hospitals totaled about $226 million in FY 05, or about 3.7 percent of total statewide hospital expenses. The medical assistance underpayments exact varying burdens on hospitals in Connecticut, depending on: the percentage of Medicaid and SAGA populations the hospitals serves; whether the services provided are inpatient or outpatient; the hospital's payer mix; and the percentage of costs Medicaid is paying of the hospital's costs.

Medical assistance populations. As noted in the briefing package, about 40 to 50 percent of the Medicaid (fee-for-service and managed care) and SAGA populations are concentrated in five Connecticut cities -- Hartford, Bridgeport, New Haven, Waterbury, and New Britain. In FY 05 there were slightly more than 70,000 Medicaid and SAGA inpatient hospital stays, about 16.7 percent of all inpatient stays statewide. Four hospitals, all located in large cities, handled about 42 percent of all Medicaid discharges and almost 47 percent of Medicaid inpatient days in the state. On the other end of the spectrum, seven hospitals in the state each have percentages of Medicaid patients below 1 percent of the total. Table I-4 outlines that distribution.

Table I-4. State Medicaid Volume – Hospitals with Highest Percentage of Total Statewide Medicaid

Hospital	Percentage of Inpatient Stays	Percentage of Inpatient Days
Yale-New Haven	16.6%	18.8%
Hartford	9.32%	11.7%
St. Francis	9.14%	9.1%
Bridgeport	6.80%	7.3%
Cumulative % of top volume hospitals	41.86%	46.9%
Bradley, Greenwich, Johnson, Milford, New Milford, Rockville, Sharon	Low-volume Medicaid – Each under one percent of Medicaid stays	

Source: LPR&IC Analysis

Medicaid revenues to hospitals. The committee examined the Medicaid revenues each hospital gets as a percentage of the total state Medicaid revenues (before DSH payments) and found the top five hospitals receive almost half of all Medicaid revenues as listed in Table I-5.

Table I-5. Hospitals Receiving Greatest Share of All State Medicaid Payments- FY 05		
Hospital	Percentage of All Medicaid Payments	Percentage of Inpatient Medicaid Payments
Yale-New Haven	17.8%	20.2%
Hartford	9.7%	10.8%
St. Francis	7.4%	7.3%
Bridgeport	6.2%	6.0%
Cumulative % of these top volume hospitals	41.1%	44.3%
CCMC	7.6%	8.9%
Cumulative with CCMC	48.7%	53.2%

With the exception of Yale-New Haven, the high volume Medicaid hospitals account for a greater percentage of the inpatient care than their percentage of Medicaid revenue. But, because the Medicaid payment structure is cost-based (albeit not recent cost) and Yale- New Haven has a higher target rate, that hospital receives a higher portion of the overall Medicaid revenues.

Some hospitals that serve a high percentage of the state's Medicaid population may be better able to shoulder that financial burden, because the Medicaid population is not that high a proportion of those hospitals' overall patient populations. The briefing package noted the Medicaid inpatient hospital volume for FY 05 was 16.7 percent statewide and the median by hospital is 15.1 percent. For five hospitals, Medicaid patients accounted for more than 20 percent of their inpatient stays. These hospitals are listed in Table I-6. Three of those hospitals also account for a high Medicaid percentage of all inpatient days, which are listed in Table I-7. However, St Mary's and Waterbury Hospitals are among the top hospitals by percentage of discharges but not of inpatient stays.

Table I-6. Hospitals with High Medicaid Population as A Percent of Overall Discharges -- FY 05	
CCMC	43.1%
Bridgeport	24%
Yale-New Haven	24%
St. Mary's	20.8%
Waterbury	20.3%

Table I-7. Hospitals with High Medicaid Inpatient days as a Percentage of All Inpatient Days	
CCMC	43.4%
Yale-New Haven	21.9%
Bridgeport	20.9%
John Dempsey	18.9%
Hartford Hospital	15.6%

Inpatient and outpatient revenue. Whether a hospital serves a greater percentage of its medical assistance clients on an inpatient rather than outpatient basis may also have an impact on medical assistance revenues and the hospital's financial condition. Medicaid fee-for-service outpatient rates are set based on an established fee schedule (e.g., $57.13 for an EKG), or based

on a statewide cost to charge ratio. In either case, since the rates are not based on a specific facility's costs, all hospitals get paid the same amount for a given test or service. The outpatient fee schedules were adjusted for increases effective July 1, 2006, but prior to that date most outpatient payment rates had not been adjusted since 2001. It is difficult to specifically assess the financial impact that serving Medicaid clients on an inpatient versus outpatient basis has on a hospital, or even what the client utilization of outpatient services are because there are no comprehensive outpatient data, including for the Medicaid population.

DSS provided FY 05 claims payment information for the Medicaid fee-for-service population, and the data indicated there were 456,311 outpatient claims for which hospitals were paid about $80 million, averaging about $175 per claim. For the same period, DSS paid hospitals about $188.7 million for about 77,000 fee-for-service and SAGA inpatient claims, averaging about $2,441 per claim. Obviously, hospitals must see many more Medicaid clients on an outpatient basis to generate a similar amount of inpatient revenue.

The average percentage of payments for inpatient services for Medicaid statewide is 58.5 percent, but the median is only 51.3 percent indicating that some of the larger hospitals derive more of their Medicaid payments from inpatient care than the average. Indeed, five hospitals derive 65 percent or more of Medicaid payments from inpatient versus outpatient services – CCMC, Yale-New Haven, Hartford, John Dempsey, and Norwalk. Interestingly, while Bridgeport serves a high inpatient Medicaid population, it derives less than the average (57 percent) of its Medicaid payments for inpatient services.

Thus, even though the inpatient rates have not been adjusted to reflect higher costs in a number of years, the higher-paid hospitals like Yale and Dempsey have inpatient rates much higher than the average, so they get a disproportionate share of Medicaid inpatient payments, bringing up the statewide percentage of Medicaid revenues on the inpatient side.

Medicaid payment-to-cost ratio. Medicaid fee-for-service inpatient rates are based on a hospital's costs, but the costs have not been readjusted in years. Therefore, hospitals that had lower costs when the rates were first established have experienced a greater gap in what Medicaid pays them and their actual costs. The five hospitals that have the lowest Medicaid payment-to-cost ratio are shown in Table I-8. Also listed in the table are the overall operating expenses per case mix adjusted equivalent discharge (CMAED), a measure which includes outpatient and inpatient services, for each of the lowest Medicaid paid hospitals. As the table shows, these hospitals for the most part do not have high operating expenses compared to the overall state average, and, in fact, four of the five hospitals are at least $1,000 below the statewide average and only one is above.

It is also worth noting that, except for Day Kimball, hospitals that receive the lowest Medicaid payment-to-cost ratio have considerably lower than the statewide average percent of revenue coming from inpatient rather than outpatient services.

Table I-8. Lowest Medicaid Payment-to-Cost Ratio Hospitals: FY 05			
Hospital	**Medicaid Payment Ratio**	**Operating Costs per CMAED**	**% Medicaid Inpatient**
St. Mary's	0.47	$5,825	50.6%
Charlotte Hungerford	0.58	$4,778	34.5%
Backus	0.60	$5,943	47.9%
Day Kimball	0.62	$6,060	58.9%
Lawrence and Memorial	0.65	$7,514	56.1%
Statewide Average	0.73	$7,054	58.4%

Underpayment and hospital expenses. To gauge the financial impact of medical assistance underpayment on a hospital, program review looked at the amount of underpayments (before any disproportionate share payments) as a percentage of each hospital's operating expenses. Three hospitals incurred underpayments that exceeded 7 percent of operating expenses –Bridgeport (8.2 percent), Yale-New Haven (8.2 percent), and St. Mary's (7.7 percent). Another five hospital incurred underpayments that exceeded 5 percent of hospital expenses. *For most hospitals -- 22 of the 31 -- the financial impact of medical assistance underpayments was greater than the costs of uncompensated care (free care and bad debt).*

Even after the payments from the state's disproportionate share programs are included in the analysis, the three most impacted hospitals – Bridgeport, St. Mary's, and Yale-New Haven -- still had percentages of underpayments to total hospital expenses of more than 5 percent.

Ability to shift costs. *Some hospitals are better able to withstand the impact of the medical assistance underpayments if the gap can be shifted onto their private payers.* Hospitals with the highest private payment-to-cost ratios have had positive financial margins, even those with a high Medicaid population, like New Britain General Hospital (see Table I-9).

If a hospital is unable to shift costs to private payers, it is much less likely to have a positive operating margin, even if it has low expenses. Four of the six hospitals with the lowest private payment-to-cost ratios have negative operating margins. Two of those hospitals with the lowest private payment ratios – St. Mary's and Charlotte Hungerford –also are the lowest paid by Medicaid, and also have the lowest adjusted operating expenses of all hospitals in the state. *Thus, certain hospitals have little room to negotiate with private payers on costs, and are also absorbing low reimbursement from Medicaid.*

Table I-9. Comparison of Private Payment-to-Cost Ratios			
Highest Private Payment-to-Cost Ratio		**Lowest Private Payment-to-Cost Ratio**	
Mid-state	1.45	Ct. Children's Medical Ctr.	.90
Danbury	1.40	St. Mary's	.96
Stamford	1.35	Dempsey	1.02
New Britain	1.35	Charlotte Hungerford	1.04
Backus	1.33	Griffin	1.06
		Waterbury	1.06
Statewide Average	**1.20**	**Statewide Median**	**1.22**
Source of Data: Office of Health Care Access			

Rate exceptions. Connecticut hospital facing deteriorating financial conditions is not new. In February 2004, as part of the state mid-term budget adjustments, about $2 million was allocated for rate relief for four hospitals – Windham, New Britain, Waterbury, and St. Mary's – determined to be in "dire financial situations". The rate adjustments they received were retroactive to October 1, 2003, and increased their target rate permanently.

Also, that budget adjustment included a plan to raise the minimum target rates in three steps to reach $4,250 in October 1, 2006. However, 2005 legislation modified that floor adjustment to $4,000 to take effect on October 1, 2006.

While not specifically approved legislatively, the rate relief through exception practice introduced in FY 04 has continued. In addition to the four hospitals that received the initial exceptions in 2004, Bridgeport, Hartford and Norwalk hospitals have received rate adjustments. Further, Norwalk and Windham have had two rate adjustments from FY 04 through October 1, 2006.

This rate exception program for hospitals is similar to the one program review committee found when it conducted the study on Medicaid nursing home rates (2001). *The informal system does provide aid to hospitals in financial crisis, but as an informal system, it has little transparency, and provides no notification to all hospitals of its availability.*

While the informal system can have advantages in cost containment (the committee reviewed rate exception files and found at least two examples where hospitals agreed to administrative salary caps), it places a great deal of financial discretion in the administrative agency. Further, while operating in an ad hoc manner, the program extends beyond grant assistance, because hospital rates are adjusted permanently.

Summary of Findings

The current Medicaid inpatient rate setting system in Connecticut:

- *is outdated and used in very few states;*
- *requires burdensome cost reporting from hospitals, even when it has little bearing on adjusting a target rate;*
- *favors higher-cost hospitals, and further favors inpatient treatment at those high cost hospitals;*
- *does not consider acuity of Medicaid patients, even in a general way;*
- *contributes to the poor financial condition of some hospitals; and*
- *has prompted a parallel informal "rate exception" process to develop.*

To address the inequitable and inadequate rate setting system, program review recommends that:

Beginning October 1, 2007, the Department of Social Services shall establish a hospital inpatient Medicaid Fee-for-Service reimbursement program adopting a prospective payment system that incorporates a case mix index. The system shall use as a base payment rate the most current available Medicare base rate adjusted by the Medicare wage index.

The rate shall account for the Indirect Medical Education (IME) expense for teaching hospitals. DSS shall adjust the rate by the difference in the base rate and the rate with the IME, and apportion the percentage of the amount difference by the ratio of inpatient Medicaid discharges to the total inpatient discharges at that hospital for the most recent year reported to Office of Health Care Access.

DSS shall then adjust the rate using the Medicare DRG case mix index for the Medicaid population for that hospital.

DSS shall adjust the base rate annually by the same percentage as the Medicare hospital market basket adjustment for inpatient payments.

DMHAS shall use this rate-setting structure to pay for inpatient SAGA services.

Implementation. Medicare base rates are established using the most recent Medicare cost reports to adjust the wage indexes for areas of the country. Thus it is a current reflection of much of actual hospital costs. Further, the variability in the Medicare base rate adjusted for wage index is a lot less than the FY 05 targeted discharge under Medicaid, as shown in Table I-10.

Table I-10. Comparison of Medicare and Medicaid Base Rates

Medicare		**Medicaid**	
Average Base Rate per stay (with wage adjustment)	$5,499	Average Targeted discharge rate per stay	$4,313
Standard deviation	$212	Standard deviation	$963
Range	$5,301 - $5785	Range	$3,438 -- $7,797

Setting the new Medicaid FFS rate at the Medicare rate raises the overall floor for all hospitals but is more reflective of more current general costs of all hospitals. The proposed rate system would consider the extra expenses of medical education in teaching hospitals. Generally, because Connecticut has a high number of teaching hospitals, hospital costs are higher. In fact, the indirect medical cost portion adds $500 a day to the average Medicare base rate, bringing it to $5,999.

Figure I-3 illustrates how the new Medicaid rate would be developed. The recommended Medicaid payment system would recognize the higher costs of the teaching hospitals by taking the difference in the IME-adjusted rate from the base rate and apportioning that difference by the ratios Medicaid inpatients are of the hospital's total population. For example, if a hospitals

Medicare IME rate is $500 higher than its base rate, and 10 percent of the hospital's discharges are Medicaid, the IME adjustment would raise the hospital's per stay rate by $50.

Figure I-3. Illustration of the Proposed Methodology for Medicaid Rate-Setting	
Sample Hospital	*Method*
$5,500 ($500 X .10= $50) + $ 50 $5,550	1) Base Rate with Medicare Wage Index 2) With Medicare IME Adjustment (for example $500) DSS Uses Inpatient Medicaid -- example 10% -- to Apportion Medicaid teaching adjustment
$5,550 X.90 **$4,995**	3) Teaching adjusted rate is multiplied by the case mix index of the Medicaid population (all Medicaid and SAGA) as reported to OHCA on CHIME. In this example case mix is .90 4) $4,995 is prospective case mix adjusted inpatient Medicaid rate for that hospital for the year

The rate with the teaching hospital adjustment is then multiplied by the case mix adjustment factor for the Medicaid population, which hospitals report to OHCA. Hospitals use the current Medicare DRGs and weights to calculate the case mix index (CMI). The FY 05 Medicaid case mix for each hospital is shown in Appendix A. For most hospitals, the case mix index for Medicaid is less than 1.

For cost-estimating purposes, the committee then multiplied the Medicaid CMI- adjusted rate by the number of FY 05 Medicaid discharges (which includes all Medicaid and SAGA inpatients) to arrive at the costs of the new rates through the proposed structure. While technically, the new rate setting structure would not apply to Medicaid managed care, for cost estimations, The committee used all Medical assistance discharges and revenues. Appendix A shows what the new payment rate adjustments would be for each hospital and the total hospital inpatient payments under the proposed system. The committee estimates the new inpatient payment structure would increase inpatient Medicaid costs by about $30.8 million dollars, but since Medicaid reimburses 50 percent of Connecticut Medicaid costs, net state costs would be about $15.4 million.

Rationale

The committee believes the proposed prospective payment system, with a case mix adjustment, is a fairer system that offers more stability to the state's overall funding of hospitals and more closely ties the payments to the patients' illnesses, rather than to a particular hospital's costs.

The proposed recommendation acknowledges that hospitals would not be held harmless. Some hospitals would experience an increase in Medicaid inpatient revenues, while Medicaid payments to other hospitals would decrease. However, the committee believes the proposal levels out the payment system by recognizing all hospitals' basic costs. Using a case mix adjustment recognizes the acuity of the Medicaid population, as well as Medicaid's portion of the extra costs at teaching hospitals.

The committee chose the Medicare DRG case mix adjustments because of its simplicity, and because all hospitals already use it to code for payment for Medicare patients. Further, 24 states currently apply the Medicare DRGs to set state Medicaid rates. There are newer, sophisticated grouping systems (e.g., APR-DRG) that more accurately categorize severity of illness, especially for a non-Medicare population. But the committee believes requiring that a newer grouping system be adopted would create a costly administrative burden, especially on smaller hospitals, for a relatively limited portion of hospital revenues. (All inpatient Medicaid FFS and SAGA revenues are about 5 percent of all hospital payments.)

A very small number of states are moving to the all patient refined (APR) DRG system for payment structures. Maryland currently uses the system, but that state sets hospital rates for all payers. The Agency for Healthcare Research and Quality (AHRQ), a section of the federal Health and Human Services Department, uses the APR-DRG system to evaluate and measure quality and outcomes of many aspects of nation's healthcare system. The committee understands that the Center for Medicare and Medicaid Services is considering moving to an APR-DRG system to set Medicare rates. If and when CMS does that, because Medicare is such a large payer, its payment system will drive the change to an APR-DRG system, and Connecticut could then adopt that system for Medicaid as well.

Committee the committee also examined a simple rebasing system where all estimated inpatient expenses divided by all discharges yielded a current inpatient expense per discharge. The same case mix adjustment was applied to yield an adjusted per stay rate for Medicaid, and the weight- adjusted rate was multiplied by the number of Medicaid discharges for FY 05, with a resulting increase in inpatient Medicaid costs of $228 million. With a 50 percent match from the federal government, the net increase in costs to the state under a rebasing would be about $114 million, an added expense that would certainly bump up against the state's spending cap, and would perpetuate a system of rewarding higher-cost hospitals.

Medicaid Managed Care Rates

Department of Social Services negotiates rate increases with Medicaid managed care organizations (MCOs) annually. The Balanced Budget Act (1997) and federal CMS regulations (2002) require that state Medicaid rates paid to managed care organizations be "actuarially sound." Prior to that, the state, through the MCOs, could not pay more for a particular service than the state would have paid if it were reimbursing the provider directly.

However, a recent report by The Lewin Group[2], a nationally recognized health consulting firm, under contract with the Association of Community Affiliated Plans to conduct an assessment of the "actuarial soundness", noted two major problems with these requirements:

1) "the exact meaning of the phrase "actuarially sound" not defined as it applies to health plans, is still being debated within the actuarial profession – with the likely outcome that different definitions will be considered appropriate for different situations;

2) in theory while this ["actuarial soundness"] is the way Medicaid managed care rates are supposed to be established, the report states Medicaid payments in practice often are affected by the availability of funds, (just as they are in Medicaid FFS) and sometimes [budget considerations] override actuarial principles.

DSS has contracted with Mercer Health Care Consulting to perform the actuarial analysis to establish Medicaid MCO rates. The firm also collects and maintains the encounter data from the MCOs on which the rates are based. Encounter data are also used by DSS to monitor utilization levels and access to care. The contract with Mercer was begun in 1997 and has been extended a number of times; the annualized cost of the contract over the 10-year period is $2 million.

The committee believes that, in addition to the problems with the MCO rate setting process noted in the Lewin report, there is another complication with the Medicaid managed care rate process that directly impacts hospitals. While managed care plans negotiate with DSS on what rate increases they will accept (or lose the Medicaid business), the MCOS then negotiate with medical providers, including hospitals, on how much the MCOs will reimburse them for care. Many private community providers may not accept the Medicaid rates offered and therefore opt not to treat Medicaid patients. Hospitals, however, are required by federal law to treat all patients who come to an emergency room, regardless of type or lack of insurance.

Aggregate financial data for the Medicaid MCOs are presented in Table I-11, and indicate that revenues to the MCOs from the state have increased about 70 percent from 2000 to 2005. Because MCOs negotiated rates for providers are considered proprietary, PRI did not have access to those rates for hospitals (or other providers). The committee also did not have hospital payments from Medicaid for the entire 2000-2005 period.

However, analysis of available MCO financial data from 2003 to 2005 show MCO per member per month (PMPM) rates increased about 10 percent over the two year period -- from $174.18 to $191.27 per month. The average inpatient payment per discharge to hospitals for an MCO inpatient stay increased only 1.8 percent, as shown in Table I-12.

[2] The Lewin Group. *Rate Setting and Actuarial Soundness In Medicaid Managed Care,* January 2006

Table I-11. Medicaid Managed Care -- Revenues and Expenses: 2000-2005							
All Plans	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**% Ch**
Member months	2,809,931	3,019,068	3,472,764	3,714,506	3,814,039	3,894,124	38%
Revenue	$438,048,971	$487,699,544	$595,415,309	$647,012,614	$698,919,818	$744,833,775	70%
PMPM Rate	$155.89	$161.53	$171.45	$174.18	$183.24	$191.27	22.6%
Medical Expenses	$381,003,060	$447,653,540	$531,288,294	$588,667,069	$628,984,044	$678,629,128	78%
Administrative Expenses	$43,869,414	$42,331,445	$52,993,196	$59,654,084	$69,658,661	$79,862,932	82%
Total	$424,872,474	$490,081,419	$584,281,490	$648,321,153	$698,642,705	$758,492,060	79%
Medical Loss Ratio	88%	92%	89%	91%	90%	91%	
Administrative Expense Ratio	10%	9%	9%	9.2%	10%	10.7%	
Margin	2%	0%	2%	-0.1%	0.2%	-1.2%	
Source: Medicaid Managed Care Council Analysis of MCO Plan Financial Data							

Table I-12. Inpatient Stays and Payments for Medicaid Managed Care – FY 03 – FY 05				
	FY 03	**FY 04**	**FY 05**	**% inc**
Total MMC Inpatient Stays	33,853	35,273	36,635	8.2%
ALOS*	3.9 days	4.0 days	4.0 days	2.5%
Total MCO inpatient hospital payments				
Average Discharge Payment	$3,853	$3,963	$3,925	1.8%
Average Per Diem MMC	$976	$983	$845	-13.4%
Source of Data: PRI Analysis of Hospital Schedules Filed with OHCA. *ALOS- average length of stay				

Further, even though the average hospital length of stay for this population increased slightly from 3.9 days to 4.0 days, the average hospital per diem payment actually went down from $976 to $845 over the two-year period. In order to fully determine the reasons for the increases in state payments to MCOs, trends in other Medicaid managed care expenses, like pharmaceuticals, would need to be analyzed.

For the same FY 03 to FY 05 time period Medicaid MCOs medical expenses increased about $90 million (or about 15.6 percent), while their administrative expenses increased $20.2 million, or 33 percent. *It appears that much of the rate increases to Medicaid MCOs has gone to increased MCO administrative expenses and have not been passed on to providers, at least not to hospitals.*

The committee recommends that the Department of Social Services require as part of the contracts with Medicaid managed care organizations that rates to providers

increase by at least the same percentage as the per member per month increase and limit the increase in administrative expenses to the same ratio as the increase in the per member per month rate.

Emergency room visits. One of the foundations of managed care is that a MCO take the financial risk of insuring appropriate medical care for enrollees for a given rate. A plausible benefit of ensuring access to appropriate care is to reduce the number of inappropriate visits to the emergency room. However, in the case of Medicaid managed care, there may not be enough financial incentive for MCOs (or their clients) to make sure their enrollees have access to and are receiving preventive, primary care in the most appropriate setting.

Until July 2006, the Medicaid outpatient fee-for-service rates for hospitals had not increased since 2001. The payment rate ER visit prior to July 2006 was $124.87 (increased to $198.63 as of July 1). But, if the ER visit was deemed (i.e., coded) not an emergency, then the rate the hospital received was a clinic rate. Prior to July 1, 2006, the clinic rate was $34.80 and increased to $69.70 after that date. However, even the increased rate is lower than the federally qualified health center (FQHC) rate of $122 to $144 (as of October 1, 2006) for a medical clinic visit.

Hospital representatives indicate that MCOs still use the Medicaid fee for service rates as the standard for their payment. The committee asked DSS for MCO outpatient encounter and claims data, similar to the data the department provided for its Medicaid fee-for-service clients. The committee had hoped to determine from the requested data where Medicaid MCO clients were receiving their medical services. However, because of computer system problems and other issues around retrieving the data, DSS was not able to get the information to the committee for this report. It is clear from other hospital emergency room data however, that the use of the ER has not gone down for the Medicaid managed care population. In fact it has increased about 10 percent over the past two years -- from 70.5 to 77 visits per 100 enrollees.

The committee believes there should be a stronger financial incentive for Medicaid MCOs to ensure their clients have access to and use preventive care in the most appropriate setting. Therefore, the committee recommends that the **Department of Social Services, in its contracts with Medicaid managed care organizations place a cap on the number of emergency room visits per MCO client. The MCO would incur a financial penalty -- $100 a visit – for a client who uses the emergency room more than twice in a year when the visit is coded as a non-emergency. DSS should use the encounter and claims data to determine when this occurs and adjust its payments to the MCOs. The penalty adjustments would be pooled and used to supplement funding to hospitals that served those clients.**

Other states have experienced inappropriate use of the emergency room by Medicaid clients, and are trying to deal with it in different ways. New Hampshire, for example, recently imposed a $6 co-pay for Medicaid clients who use the emergency room inappropriately. However, hospitals must collect the co-pay at the time of service, and cannot refuse treatment to anyone who states he or she cannot pay. Thus, the burden is still on the hospital for treatment and payment collection. The committee believes making the MCOs bear more financial responsibility for appropriate medical care for their clients is a better approach because it

encourages MCOs to make sure their clients have access to appropriate preventive and routine health care.

Outpatient revenues. Altogether state medical assistance program payments to Connecticut hospitals totaled $574 million, about $276 million from managed care $298 from FFS. Medicaid managed care pays about 48 percent of its hospital payments for outpatient services, while outpatient payments for Medicaid fee-for-service account for only about 35 percent of its hospital payments. However, there are no comprehensive utilization data to assess per- patient outpatient costs for either of the Medicaid populations.

For the vast majority of providers, outpatient rates are not based on hospital or provider costs -- FQHCs are the exception. DSS establishes the rates -- either on a set fee schedule, or on an overall ratio of cost to charges for a given service. DMHAS has its own rates for SAGA clients' behavioral health. Even though the DSS rates are low, they are the same for all hospitals (SAGA rates vary slightly by hospital), so higher cost hospitals are not getting paid a higher amount for the same service, and hospitals know ahead of time what rates they will be paid.

Until July 2006, the fee for service rates for most outpatient care had not been increased in five years. In the FY 07 budget, the legislature authorized an increase of $7 million to increase outpatient rates to hospitals, including: lab fees; emergency room visits; and clinics. The rate increases will help hospitals, especially those with a high percentage of outpatient Medicaid volume. Historically, fee schedules have been thought to raise costs by increasing utilization. That is difficult to assess for this study, because no utilization data exist for all Medicaid clients.

Medicare, the largest single-source payer, for the most part uses a prospective payment system (adjusted by wages), known as the ambulatory payment classification (APC) to set outpatient rates. Massachusetts uses a prospective payment amount per episode (PAPE), which is an all-inclusive rate that covers all outpatient services for persons when they are treated. The PAPE rates vary considerably by hospital from $125 to $350 at general hospitals to more than $500 at several specialty hospitals. However, the committee believes that to recommend adopting an outpatient payment structure based on different hospital costs -- while moving away from such a system for inpatient care -- would contradict the purpose of promoting fairness in reimbursement to hospitals.

Therefore, the committee recommends maintaining the current outpatient reimbursement structure, but believes the rates should be increased annually. The committee recommends that DSS adjust the outpatient rates by increases in the Consumer Price Index (urban).

The committee believes that some annual adjustment should be made to outpatient rates to reflect inflation, and provide some assurance that Medicaid clients have access to those services. Not updating the payment schedules for years at a time limits access to outpatient services and ultimately could drive up more costly inpatient care. On the other hand, containing costs is an overriding concern in the state Medicaid program. The committee considered applying an adjustment factor based on medical inflation, or using the same annual increases as Medicare outpatient, but determined using either of those will likely lead to unsustainable

increases. Therefore, the recommendation proposes annual increases, but limits those to inflationary changes in the overall economy, which have typically been lower than increases in health care. With this proposal, more moderate, but frequent, adjustments will be applied, ensuring a closer connection between outpatient service costs and payments, and assuring better Medicaid client access to those services.

The committee recommends, however, that, while maintaining the per-service fee schedule, DSS through its payment contractor – Electronic Data Systems – ensure that hospitals (or any other provider) are not over-utilizing certain services per episode to increase outpatient payments. DSS and DMHAS, as payers, should also increase monitoring of payment of inpatient care for its clients to ensure that such care is necessary and appropriate, and could not have been provided on an outpatient basis.

Chapter II

Additional Financial Assistance

In addition to the various rate reimbursement systems and rate exceptions discussed in Chapter I, there is a selection of other financial assistance opportunities available to hospitals. Among these are the hospital hardship grants appropriated in 2006, the rate adjustments for hospitals serving a disproportionate share (DSH) of low-income individuals, as well as additional payments for under-insured and uninsured clients. However, some of the assistance (i.e., hardship grants) are considered one-time opportunities. *The level and availability of the other forms of financial assistance is unpredictable and not open to all hospitals.*

Hardship Grants

Recognizing the need for financial stability, the legislature in the 2006 session authorized DSS to distribute $11 million for hardship grants to Connecticut hospitals (P.A. 06-186). The grants were to help hospitals: avoid substantial financial deterioration that may adversely affect patient care, and assist in their continued operation. Hospitals were notified in August 2006 of the availability of funds and the application process.

DSS determined grant recipients in consultation with the Department of Public Health, the Office of Health Care Access, and the Connecticut Health and Educational Facilities Authority. Pursuant to the public act, consideration was to be given to the number of clients on state assistance that a hospital serves; the hospital's licensure and compliance history; and the reasonableness of its actual and projected revenues and expenses. Table II-1 lists the hospitals that applied for the hardship funds.

Table II-1. Hospital Hardship Fund Request
Bradley/New Britain
Bridgeport
Bristol
New Milford
Rockville
St. Mary's
St. Raphael
Waterbury
Windham
Source: DSS

To qualify, a hospital was required to submit a plan describing how the hospital would achieve operating savings and increase nongovernmental revenues. Quarterly reports on plan implementation are required for continued grant payments. DSS must submit quarterly reports to the Appropriations and Human Services committees identifying the hospitals asking for grants, the grant amounts, and the commissioner's action on each request.

The program review committee examined the application submissions received by DSS for the hardship funds. In general, each hospital applicant was judged in three main categories. The categories and specific application requirements were as follows:

I. Financial Condition

Each hospital applicant was required to submit audited financial statements and Internal Revenue Service 990 filings for FY 2004 and 2005. The submissions were to include a

description of the hospital's financial condition and projections for the next two fiscal years including key revenue and/or cost factors affecting the hospital's financial performance.

In addition, a review was made of the applicant's total amount of outstanding debt, the payment schedule on the debt, and the probability of the applicant violating covenants in any loan agreements as well as information pertaining to hospital credit lines.

II. Utilization Statistics

Pursuant to the public act, each hospital was required to submit selected utilization statistics. Specifically, each hospital was to report volume for low-income inpatient, clinic, and emergency services for 2004 and 2005.

III. Planned Use and Projected Operating Savings

Each hospital was to explain its' planned use of grant funds and expected results as well as to project savings and non-governmental revenue enhancements planned between October 1, 2006 and June 30, 2007. Each applicant was also to identify if any such activities would be a one-time or ongoing/long-term initiative.

Each applicant's plan was evaluated on the basis of the benefit to state assisted and uninsured individuals and the feasibility of the plan in light of the hospital's financial condition. In addition, each applicant's projected savings and enhancements were reviewed for reasonableness.

Summary of applicant submissions. Table II-2 provides a limited profile of the nine hospital applicants. As the table shows, five of the applicants are teaching hospitals. Three hospitals had fewer than 90 staffed beds, two had between 150 and 170 staffed beds, and four had more than 280. Three hospitals were in New Haven county, two in Hartford county, and one each from Fairfield, Litchfield, Tolland, and Windham counties. In addition, six of the nine hospitals had negative operating margins in 2005 including Bradley, which is now merged with New Britain.

Table II-2. Profile of Hardship Grant Applicants

Hospital	County	Teaching	FY 2005	
			Staffed Beds	Operating Margin
Bradley/New Britain	Hartford	No/Yes	46/290	-2.55 / 4.94
Bridgeport	Fairfield	Yes	335	2.72
Bristol	Hartford		154	-4.19
New Milford	Litchfield		72	1.05
St. Mary's	New Haven	Yes	169	-10.02
St. Raphael	New Haven	Yes	474	-1.20
Waterbury	New Haven	Yes	288	-1.17
Windham	Windham		87	0.06
Rockville	Tolland		66	-4.48

Source: LPR&IC Analysis

With respect to their financial conditions, almost all the hospitals noted their financial conditions were impacted by losses from operations and low government rate reimbursement. Some cited a growing number of uninsured and underinsured patients creating financial shortfalls. A few voiced concern over their debt service. Two specifically mentioned losses due to changes in the Medicare wage index areas.

Utilization rates. Table II-3 presents the utilization statistics selected by DSS to be submitted as part of the hardship grant applications. Of the three statistical areas under review, the highest utilization was seen in clinic and emergency room use among the low-income population. Bridgeport reported the highest percentage of utilization of low-income populations in all three areas of inpatient, clinic, and emergency room. St. Raphael and St. Mary's reported large percentages of low-income and uncompensated care populations in their clinics and emergency rooms. Finally, Windham Hospital also had high utilization rates for inpatient and emergency room use by low-income individuals.

Planned use of grant funds. Each hospital applicant discussed its planned use of hardship funds. The plans varied in purpose and level of detail. Table II-4 lists each hospital's primary planned use as reported in the application. Each hospital also noted that although these plans were identified as priorities, several other critical needs were still pending.

Table II-4. Applicant Reported Planned Use for Hardship Grants

Hospital/Applicant	Planned Use
St. Raphael	Meet current liabilities as they become due, fund pension expenses, and address capital investments
New Milford	Offset loss due to reclassification of the hospital's Medicare wage index area and to prevent or reduce the need for layoffs of personnel due to increases in various costs including utilities, pensions, wages, and malpractice insurance
Windham	For use as strategic capital to fund projects related to medical imaging services
Rockville	Offset the start-up costs related to building up operating room inventory to support the restoration of certain inpatient services and help fund the capital budget for renovations and/or equipment
St. Mary's	Deficit reduction and meet debt service obligations as well as funds for employee pensions, information infrastructure, and a number of physical plant projects
Bristol	Support registered nurse investment strategies, emergency department improvement initiatives, and the cancer program
(New Britain/Bradley) Hospital for Central Connecticut	Streamline administrative and management systems due to merger
Waterbury	Update the hospital's imaging technology and increase available bed capacity for inpatient care
Bridgeport	Support medical staff recruitment to address physician retirements in the areas of general surgery, psychiatry, and geriatrics
Source: DSS Hardship Applications	

Table II-3. Selected 2004 and 2005 Utilization Statistics Submitted as Part of Hospital Hardship Grant Application													
		Inpatient				Clinic				Emergency Room			
Hospital	FY	Total	Low Income %	UCC %	All Other %	Total	Low Income %	UCC %	ALL Other %	Total	Low Income %	UCC %	All Other %
St. Raphael	04	142,977	14	6	79	68,306	62	20	18	39,210	31	28	42
	05	131,347	15	5	80	69,489	62	18	20	41,303	34	21	45
New Milford	04	14,352	6	11	83	76,223	5	3	92	19,049	8	18	73
	05	14,747	6	9	85	78,465	5	3	92	19,533	4	18	78
St. Mary's	04	54,200	11	1	88	69,512	71	5	24	52,044	23	10	67
	05	55,099	11	1	88	75,913	73	5	22	55,165	17	9	74
Rockville	04	16,097	14	5	81	68,744	6	2	92	18781	19	2	78
	05	15,620	15	8	77	69,367	6	2	92	19,034	21	2	76
Windham	04	20,958	20	6	74	825	13	63	23	21,258	30	18	52
	05	20,261	18	15	67	669	13	67	20	22,401	33	27	40
Bridgeport	04	107,646	24	10	66	31,753	72	17	11	52,136	43	26	32
	05	107,947	23	14	62	34,186	70	17	13	53,567	43	24	33
Bristol	04	36,826	13	16	71	134,621	9	10	81	31,007	30	32	38
	05	36,810	14	17	70	127,405	9	9	82	32,084	31	30	39
Waterbury	04	79,072	17	12	72	131,582	15	0	85	44,581	32	0	68
	05	81,131	18	11	71	123,399	14	0	86	45,506	33	0	67
Bradley	04	2,323	3	1	96	62,340	5	3	93	14,970	12	8	80
	05	2,338	3	1	96	67,676	5	2	93	14,970	15	7	79
New Britain	04	17,617	20	2	78	306,995	21	4	75	63,585	21	9	70
	05*	N/A	-	-	-	N/A	-	-	-	N/A	-	-	-

Low income includes Medicaid Fee-for-Service, Husky A/B, and SAGA
UCC includes free care and uncompensated care
* FY 05 utilization data was not included in application

Source: DSS Hospital Hardship Grant Applications

Operating savings and revenue enhancement. The hospitals each discussed a variety of savings initiatives and non-governmental revenue enhancements. Among the initiatives considered were:

- more favorable negotiations with managed care contracts;
- expense reductions related to salary, pension, and benefits;
- implementation of energy management plan and conservation improvements;
- better use of new information system to bill and collect for services rendered;
- improvements in emergency room and surgical services operations such as scheduling, staffing, and supply costs;
- conversion of employee group health insurance benefit from fully-insured plan to self-insured plan;
- consolidation of certain support services; and
- introduction of information technology to reduce redundancy in testing and other clinical diagnostic procedures.

Distribution of grants. Grant determination notices were mailed to all applicants on November 28, 2006. The notice stated DSS considered awards based upon the severity of financial difficulties and the volume/proportion of hospital services provided to state-assisted and uninsured patients. According to the notice, the grant funding was "neither intended nor sufficient to meet losses projected by all hospitals for 2007 or shortfalls between government health program payment levels and standard charges." The notice further stated the hardship funds were better suited for one-time projects such as capital improvements. Grantees were reminded grant funds were a limited appropriation and grantees should not rely on any future additional grant funds. Table II-5 lists the distribution of hardship funds as of November 28, 2006; $8.7 million of the $11 million were awarded.

Table II-5. Distribution of the Hospital Hardship Grants

Hospital Applicant	Grant Amount	Outcome/DSS Intended Purpose
Bridgeport	Pending	Must clarify need for one-time assistance for capital improvements
Bristol	$1.2 million	Expansion for additional cancer treatment capacity
Hospital of Central Connecticut (New Britain/Bradley)	$0	Based on reported profits hardship was not determined
Rockville	$0	Based on projected profits and lower utilization rates than other applicants no grant award
New Milford	$0	Based on lower utilization rates than other applicants no grant award
St. Mary's	$5.5 million	Address operating shortfalls and bond covenants
Waterbury	$1 million	Applied toward CT scan
St. Raphael	Pending	Must clarify need for one-time assistance for capital improvements
Windham	$1 million	Applied toward CT scan upgrade
Total Appropriated	**$11 million**	
Total Awarded	**$8.7 million**	
Total Remaining	**$2.3 million**	

Source: DSS Determination Notices of Hardship Grants

Medicaid Disproportionate Share (DSH) Program

The Medicaid DSH program allows states to consider special payment needs for hospitals that serve a large portion of Medicaid and uninsured patients. The rationale behind the additional payments is that hospitals with high volumes of low-income individuals often lose money as a result of low Medicaid reimbursement rates. They also lose money because these same hospitals generally provide high volumes of care to indigent patients resulting in high levels of uncompensated care. In addition, many hospitals with large caseloads of low-income patients frequently have low private caseloads. Therefore, they are less able to shift the cost of uncompensated care to privately insured patients.

Federal requirements. The Omnibus Budget Reconciliation Act of 1981 established the DSH program, which is codified in section 1923 of the Social Security Act. The section requires state Medicaid agencies to make additional payments to hospitals that serve disproportionate numbers of low-income patients.

States have considerable flexibility in defining their DSH programs under the act. States receive allotments of DSH funds as set forth by section 1923. The federal government shares in the cost of Medicaid DSH expenditures based on the federal medical assistance percentage for each state. In Connecticut, the federal government share is 50 percent.

DSH Payments and Adjustments

Connecticut acute care hospitals receive DSH monies under both Medicare and Medicaid. As noted above, states have wide discretion in how they administer Medicaid DSH funds. Table II-6 distinguishes the various types of DSH monies received by Connecticut acute care hospitals as well as who administers them.

Table II-6. Disproportionate Share (DSH) Programs for Connecticut Acute Care Hospitals

Program Name	Type of DSH	Administered by
Medicare		
Mandatory	Mandatory rate *adjustment* pursuant to federal regulation	Federal Center for Medicare and Medicaid Services (CMS)
Medicaid		
"Mandatory"	"Mandatory" rate *adjustment* pursuant to federal regulation as adopted in Medicaid State Plan	DSS
Uncompensated Care	*Payment* formula pursuant to state statute as adopted in Medicaid State Plan	DSS with OHCA
Urban	*Payment* formula pursuant to state statute as adopted in Medicaid State Plan	DSS

Source: LPR&IC

As the table shows, there are three major DSH funds administered by the Department of Social Services. Uncompensated care and urban DSH *payments* are made by DSS and paid from general fund revenues with matching funds from the federal government. Medicaid DSH *adjustments* are built into the Medicaid target rate for a few hospitals that qualify. These adjustments, also calculated by DSS, are separate from DSH payments. Hospitals also receive DSH adjustments for Medicare rates but these adjustments are handled by the federal government.

Medicare DSH adjustment. Enacted in 1983, the Medicare disproportionate share adjustment is an add-on to the diagnosis-related group rate under the Medicare prospective payment system to acknowledge the special needs of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under Part A of the Medicare hospital program. The primary method for a hospital to qualify for a Medicare DSH adjustment is based on a complex federal formula that results in a DSH patient percentage. To qualify for Medicare DSH, a hospital's share of low-income patients must equal or exceed 15 percent.[5]

Table II-7 provides the 2006 Medicare DSH percentage for qualifying hospitals along with their 2005 and 2006 adjustments. Thirteen acute care hospitals in Connecticut have a Medicare DSH percentage over 15 percent allowing them to receive Medicare DSH adjustments. Yale-New Haven has the largest Medicare DSH percentage (30%) with a rate adjustment of 0.1399; that percentage is then added to the hospital's basic Medicare rate.

Table II-7. Distribution of Medicare Disproportionate Share Adjustments FYs 05-06.

HOSPITAL	DSH %	05 Medicare DSH Adjustment	06 Medicare DSH Adjustment
Backus	20.0	0.0576	0.0576
Bridgeport	23.1	0.0825	0.0825
Day Kimball	15.7	0.0294	0.0294
Dempsey	24.7	0.0962	0.0962
Hartford	17.2	0.0394	0.0394
New Britain General	21.0	0.0650	0.0650
St. Francis	20.8	0.0641	0.0641
St. Mary's	20.6	0.0618	0.0618
St. Vincent's	21.4	0.0688	0.0688
Stamford	18.6	0.0484	0.0484
Waterbury	19.1	0.0517	0.0517
Windham	23.4	0.0851	0.0851
Yale-New Haven	30.0	0.1399	0.1399
Source: Connecticut Hospital Association Report			

[5] The low-income share is determined by summing: a) the number of Medicare inpatient days provided to Supplemental Security Income (SSI) recipients divided by total Medicare patient days, and b) the number of inpatient days provided to Medicaid beneficiaries (non-Medicare) divided by total inpatient days.

Medicaid DSH adjustment. Under the Medicaid program, states are allowed to designate certain hospitals as disproportionate share facilities under their Medicaid plans and make additional payments to those DSH hospitals by adjusting their Medicaid rates. Pursuant to federal law, DSS may provide a disproportionate share adjustment to hospitals that have a Medicaid inpatient utilization rate that is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state.[6] The hospital must also have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the state Medicaid plan.

DSS determines which hospitals meet the standard deviation criteria from information contained in the Medicaid cost reports annually filed by the hospitals. The utilization rate is calculated by dividing the total number of Medicaid inpatient days for both Medicaid managed care and fee-for-service clients by the total number of inpatient days. DSS must then calculate the mean and standard deviation for the entire group to determine the qualifying hospitals. (The DSS calculation for the 2006 Medicaid DSH adjustment is presented in Appendix B.)

To qualify for the 2006 mandatory DSH adjustment, hospitals must have a utilization rate that is at a minimum one standard deviation over the mean (17.4107). As Table II-8 shows, three hospitals (Bridgeport, John Dempsey, and Yale-New Haven) qualified for the 2006 Medicaid DSH adjustment.

Each qualifying hospital's base rate then receives a DSH adjustment add-on based on a federally prescribed formula. The DSH adjustment add-on formula is similar to the formula used for the Medicare DSH adjustment.

A comparison of the three hospitals that qualify for the 2006 federal DSH adjustment is provided in the table below. As the table shows, the addition of the DSH adjustment results in rates that are up to $800 higher than the base rate. As a result, *the Medicaid DSH rate adjustment creates a "cliff effect" whereby the few hospitals that qualify receive significant increases in their rates.*

Table II-8. Comparison of Adjusted and Non-adjusted Rates for Qualifying Medicaid DSH Hospitals

Hospital	FY 06 Base Rate w/o DSH Adjustment	DSH Adjustment	DSH Adjusted Base Rate	Difference b/w adjusted and non-adjusted base rates	FY 05 Medicaid FFS Discharges	Total Difference due to DSH
Bridgeport	$5,350	0.10697	$5,922	$572	1,964	$1,123,408
Dempsey	$7,797	0.10054	$8,581	$784	621	$486,864
Yale-New Haven	$5,151	0.15543	$5,951	$800	4,289	$3,431,200
Source: LPR&IC Analysis						

[6] The standard deviation is a statistical measure of the dispersion of hospitals' utilization rates around the average; the use of this measure identifies hospitals whose Medicaid utilization is unusually high.

Since FY 99, a total of six hospitals have qualified for Medicaid DSH adjustments. Three of the six (Bridgeport, John Dempsey, and Yale-New Haven) have qualified every year. St. Francis Hospital has qualified every year until 2006. Waterbury and St. Mary's qualified in 2001 and 2004 respectively.

The impact the Medicaid DSH adjustment has on hospital rates is substantial. As noted above, St. Francis Hospital has qualified every year since 1999 until 2006. In FY 05, St. Francis Hospital met the qualifying utilization rate and received a DSH adjusted base rate of $3,821. In FY 06, St. Francis's total Medicaid patient days decreased and the hospital did not meet the qualifying utilization rate for the DSH adjustment. As a result, the hospital went from a DSH adjusted rate of $3,821 in FY 05 to a base rate of $3,438 in FY 06, a reduction of $383 per discharge.[7]

The impact of the Medicaid DSH adjustment is also visible when comparing hospitals located in the same town presumably serving the same population. In FY 06, two of the three hospitals receiving a DSH rate adjustment (Bridgeport and Yale-New Haven) were located in cities that each had another acute care hospital. Both St. Vincent's, which is located in Bridgeport, and St. Raphael, located in New Haven, did not qualify for a Medicaid DSH adjustment. Table II-9 illustrates the difference in adjusted and non-adjusted base rates for these hospitals in FY 06.

Table II-9. Comparison of Adjusted and Non-adjusted Rates for Co-located Hospitals: FY 06

Hospital	Utilization Rate	Base Rate	Base Rate w/ Adjustment	Rate Difference b/w Co-located Hospitals
Yale-New Haven	24.7718*	$5,151	$5,951	$2,167
St. Raphael	13.4322	$3,784	Not Qualify	
Bridgeport	20.1005*	$5,350	$5,922	$2,018
St. Vincent's	12.2281	$3,904	Not Qualify	
Standard Deviation	5.4216			
Mean/Average	11.9891			
Qualifying Rate	**17.4107***			
Source: LPR&IC Analysis				

As the table shows, the Medicaid utilization rates for St. Raphael and St. Vincent's exceeded the statewide average in FY 06. However, neither hospital met the qualifying rate set by the standard deviation requirement. Consequently, both St. Raphael and St. Vincent's received the base rates while Yale-New Haven and Bridgeport had the DSH rate adjustment added on to their base rates. This translates into a difference of over $2,000 per discharge for the hospitals. Interestingly, *other hospitals also serving large urban populations (e.g., Hartford and New Britain) have not qualified for the Medicaid DSH adjustment despite growing Medicaid numbers.*

[7] The impact of this was lessened because a number of hospital rates including St Francis increased to $4,000 in FY 07 as a result of the state raising the statutory minimum base rate during the last legislative session.

In addition to the volatility and unfairness created by DSH adjustments to rates, the formula only considers Medicaid *inpatient* volume. This may create a perverse incentive for certain hospitals to treat Medicaid clients on an inpatient basis and to increase the inpatient days.

Therefore, program review recommends **DSS terminate the application of the Medicaid DSH rate adjustment.** There is no federal requirement that the state continue this practice. The Medicaid DSH rate adjustment benefits few and creates a significant "cliff effect" in the rates of a small number of hospitals. Discontinuation of the Medicaid DSH adjustment would also avoid the potential incentive of treating clients on an inpatient basis.

It is important to note that eliminating the Medicaid DSH adjustment would not mean Connecticut would lose federal funds or in effect "leave federal DSH money on the table." The proposed new Medicaid inpatient reimbursement rate would increase the state's Medicaid budget by approximately $30 million, half of which is matched by the federal government. Therefore, the state would not "lose" Medicaid money but rather redistribute the funds more fairly through the proposed Medicaid rate structure.

Calculation of DSH payments. Disproportionate share *payments*, as opposed to rate *adjustments*, refer to additional payments by the state to compensate hospitals for a portion of the services they provide to under-insured and uninsured patients. Under the Medicaid program, DSS may claim DSH payments made to acute care hospitals under certain categories defined within the state's Medicaid plan to receive federal matching funds. As noted earlier, Connecticut receives federal matching funds at a 50 percent rate.

Uncompensated Care (UCC) program. The largest DSH payment category is through the Uncompensated Care (UCC) program, which is statutorily made available to all acute care hospitals except children's hospitals and John Dempsey.

DSS determines the amount of UCC disproportionate share payments to be made to each eligible hospital based on information provided by the Office of Health Care Access. In general, DSS makes payments to qualified disproportionate share hospitals based upon: 1) the costs they incurred for uncompensated services, 2) the federal upper limit on aggregate state disproportionate share payments that are eligible for federal matching payments, and 3) the amount determined to be available under state law.

An approach known as a baseline methodology is used to determine how much each hospital is to receive in UCC DSH payments. OHCA calculates each hospital's baseline underpayment, which equals the cost of uncompensated care (bad debt and free care) and the cost of Medical Assistance underpayment (for state Medicaid FFS and Managed Care as well as SAGA).

UCC calculation. OHCA bases its calculation on information submitted in financial schedules filed by each hospital. To bring the hospital "charge" level down to a "cost" level, OHCA calculates a cost ratio using the total net revenue from all hospital payers divided by the total charges from all payers. The resulting statewide cost ratio is used to determine the total cost of uncompensated care and medical assistance underpayments.

The uncompensated care total is multiplied by the cost ratio to produce the cost of uncompensated care. The hospital's medical assistance charges that include all Medicaid and SAGA charges are also multiplied by the cost ratio to determine the cost of medical assistance. The total payments made to a hospital for Medicaid and SAGA are then subtracted from the cost of medical assistance to identify the medical assistance underpayment. Adding the cost of uncompensated care with the medical assistance underpayment produces the total cost of uncompensated care and medical assistance underpayment.

In addition to calculating and reporting each hospital's baseline underpayment to DSS, OHCA must also calculate the federal DSH upper payment limit (UPL). With the passage of the Federal Omnibus Budget Reconciliation Act of 1993, states must demonstrate to CMS that the DSH amount each hospital would receive would not exceed each hospital's specific upper payment limit. This federal restriction prohibits states from making Medicaid DSH payments that are higher than reasonable estimates of the amounts the Medicare program would pay for the same services.

To comply with this provision, OHCA determines and reports each hospital's UPL to DSS for its calculation of DSH payments. According to OHCA and DSS, this calculation usually has little relevance as Connecticut hospitals have rarely exceeded their limit. The calculation for UPL is complex; however, in general terms OHCA adds the underpayment totals for uninsured, outpatient Medicaid, and other medical assistance (SAGA) to yield the total projected underpayment according to Medicare reimbursement principles.

All hospitals with a baseline DSH payment that exceeds their UPL have their DSH payment amount reduced to the UPL. The total amount of these reductions is then redistributed to all hospitals with room under their upper limit.

The baseline underpayments and upper payment limits are provided by OHCA; DSS proceeds to determine DSH payments available to hospitals under the UCC program. Each hospital's baseline percentage of the appropriation is calculated by dividing the hospital's baseline underpayment by the statewide baseline underpayment. The hospital's percentage is then multiplied by the state DSH appropriation to calculate each hospital's DSH payment for the year. Table II-10 on the next page illustrates the 2007 distribution of the $53,725,000 state appropriation for UCC DSH payments.

As the table shows, there is a total of almost $54 million in uncompensated care DSH payments in FY 07. One hospital (Bradley) did not receive any uncompensated care DSH monies. The portion of DSH funds that Bradley would have been eligible for was redistributed among the remaining hospitals.

Table II-10. Distribution of DSH Funds Under the Uncompensated Care Program (UCP) – FY 07							
HOSPITAL	Upper Limit	Total Cost of UC & MedAss Underpayment	Baseline %	Baseline Method Payment	Room under Limit	Additional DSH	Total UCP DSH
Backus	$7,945,183	$15,053,971	3.392657	$1,822,705	$6,122,478	$1,155	$1,823,860
Bradley	$0	$485,626	0.109444	$58,799	$0	$0	$0
Bridgeport	$28,117,664	$32,366,407	7.294295	$3,918,860	$24,198,804	$4,566	$3,923,426
Bristol	$5,872,805	$5,748,416	1.295499	$696,007	$5,176,798	$977	$696,984
Danbury	$14,706,920	$23,269,814	5.244230	$2,817,463	$11,889,457	$2,243	$2,819,706
Day Kimball	$8,284,307	$7,124,218	1.605558	$862,586	$7,421,721	$1,400	$863,986
Essent/Sharon	$1,307,441	$2,230,536	0.502688	$270,069	$1,037,372	$196	$270,265
Greenwich	$6,035,826	$8,802,124	1.983702	$1,065,744	$4,970,082	$938	$1,066,682
Griffin	$3,839,752	$5,298,548	1.194114	$641,538	$3,198,214	$603	$642,141
Hartford	$45,753,146	$48,491,299	10.928301	$5,871,230	$39,881,916	$7,525	$5,878,755
Hungerford	$9,189,393	$5,326,895	1.200502	$644,970	$8,544,423	$1,612	$646,582
Johnson Memorial	$2,021,519	$1,378,305	0.310623	$166,882	$1,854,637	$350	$167,232
Lawrence Memorial	$10,629,653	$16,493,418	3.717060	$1,996,990	$8,632,663	$1,629	$1,998,619
Manchester	$3,967,450	$5,011,950	1.129524	$606,837	$3,360,613	$634	$607,471
Mid State	$9,465,282	$9,864,689	2.223168	$1,194,397	$8,270,885	$1,561	$1,195,958
Middlesex	$8,573,927	$13,160,244	2.964875	$1,593,416	$6,980,511	$1,317	$1,594,733
Milford	$1,854,305	$2,415,176	0.544299	$292,425	$1,561,880	$295	$292,720
New Britain General	$9,096,326	$12,505,438	2.818303	$1,514,134	$7,582,192	$1,431	$1,515,565
New Milford	$1,008,902	$2,208,888	0.497809	$267,448	$741,454	$140	$267,588
Norwalk	$14,807,764	$17,687,107	3.960770	$2,141,520	$12,666,244	$2,390	$2,143,910
Rockville	$1,683,921	$2,596,713	0.585212	$314,405	$1,369,516	$258	$314,663
St. Francis	$29,433,216	$33,429,786	7.533945	$4,047,612	$25,385,604	$4,790	$4,052,402
St. Mary's	$25,313,285	$15,137,383	3.411455	$1,832,804	$23,480,481	$4,430	$1,837,234
St. Raphael	$24,354,681	$22,534,451	5.078504	$2,728,426	$21,626,255	$4,081	$2,732,507
St. Vincent's	$16,247,218	$18,534,220	4.176987	$2,244,086	$14,003,132	$2,642	$2,246,728
Stamford	$17,374,940	$23,996,250	5.407944	$2,905,418	$14,469,522	$2,730	$2,908,148
Waterbury	$11,020,265	$12,963,059	2.921436	$1,569,541	$9,450,724	$1,783	$1,571,324
Windham	$3,867,719	$3,611,060	0.813811	$437,220	$3,430,499	$647	$437,867
Yale-New Haven	$43,519,937	$75,996,203	17.126978	$9,201,469	$34,318,468	$6,475	$9,207,944
TOTAL	**$365,292,748**	**$443,722,195**	**100%**	**$53,725,000**	**$311,625,546**	**$58,799**	**$53,725,000**
Source: Department of Social Services							

Urban/distressed DSH program. A third DSH program targets hospitals located in distressed communities. In 2001, the legislature established a DSH program aimed at helping hospitals in distressed municipalities with populations over 70,000. In 2003, the legislature also allowed DSH payments to hospitals located in targeted investment communities with enterprise zones and populations over 100,000. In 2006, nine hospitals were located in five distressed municipalities with populations over 70,000 (Bridgeport, Hartford, New Britain, New Haven, and Waterbury). One additional hospital is found in a targeted investment community with a population of 100,000 (Stamford). No payments can be made to a children's hospital under this program.

The payment amount for each hospital is based on the ratio of inpatient discharges paid on a Medicaid fee-for-service basis to the total number of such inpatient hospital discharges for all hospitals as reported in the most recently filed cost reports. Table II-11 provides the 2006 distribution of the $31.5 million appropriation for urban DSH payments. As the table shows, *more than half (59%) of the 2006 urban DSH funds are provided to four hospitals (Bridgeport, Hartford, St. Francis, and Yale-New Haven).*

Table II-11. Distribution of Urban DSH Funds (FY 06).

Qualifying Hospital	04 Medicaid FFS Discharges	Percent of Total	Appropriation DSH Distribution
Bridgeport	1,836	10.49	$3,312,696
Hartford	2,612	14.93	$4,712,833
New Britain	1,036	5.92	$1,869,255
St. Francis	2,210	12.63	$3,987,504
St. Mary's	866	4.95	$1,562,524
St. Raphael	1,349	7.71	$2,434,001
St. Vincent's	1,469	8.40	$2,650,518
Stamford	1,409	8.05	$2,542,260
Waterbury	990	5.66	$1,786,258
Yale-New Haven	3,709	21.21	$6,692,151
TOTAL	**17,486**	**100%**	**$31,550,000**
Source: Department of Social Services			

While the state's urban/distressed DSH program recognizes the need for additional DSH monies, the existing program definition excludes some hospitals serving similar populations. The program review committee examined the ratio of Medicaid fee-for-service discharges to total discharges for all individual hospitals in FY 05. The analysis, seen in Table II-12, shows that the Medicaid fee-for-service discharges for the hospitals that currently receive urban DSH range between six and ten percent of their total discharges. The committee found five other hospitals that had percentages within the same range -- Norwalk (8%), Danbury (7%), Mid State (6%), Dempsey (6%), and Windham (6%).

Based on population alone, Danbury (74,848) and Norwalk (82,951) hospitals would satisfy the population requirement for urban DSH. Both Danbury and Norwalk also have comparable Medicaid fee-for-service discharges to the hospitals receiving urban DSH payments. However, neither town is classified as a distressed municipality.

Table II-12. Comparison of Urban DSH Hospitals and Hospitals Serving Similar Populations					
Urban DSH Hospitals	**Population**	**Distressed Municipality**	**FY 05 FFS Discharges**	**FY 05 Discharges**	**Percent of Discharges**
Bridgeport	139,529	Y	1,964	20,109	10
Hartford	121,578	Y	3,085	39,045	8
New Britain	71,538	Y	1,134	17,610	6
St. Francis	121,578	Y	2,239	32,175	7
St. Mary's	107,271	Y	872	12,268	7
St. Vincent's	139,529	Y	1,513	19,375	8
St. Raphael's	123,626	Y	1,359	24,841	6
Stamford	117,083	Y	1,491	17,464	9
Waterbury	107,271	Y	1,023	15,535	7
Yale-New Haven	123,626	Y	4,289	48,616	9
Hospitals Not Qualifying					
Danbury	74,848	N	1,331	19,907	7
Dempsey	23,641	N	621	9,799	6
Mid State	58,244	Y	605	9,866	6
Norwalk	82,951	N	1,170	15,523	8
Windham	22,857	Y	325	5,207	6
Source: LPR&IC Analysis					

Both Mid State and Windham, which also had percentages within the same range as hospitals receiving urban DSH, are located in distressed municipalities but do not meet the population criteria. There are an additional six hospitals located within distressed municipalities that also do not meet the population criteria. Together these hospitals have populations ranging from 9,000 to slightly over 60,000. They also have Medicaid fee-for-service discharges between 245 and 672 which are between three to six percent of their total discharges. (It also bears repeating that Norwalk and Windham have twice requested and received rate exceptions.)

Therefore, the program review committee recommends **the urban DSH funds should be made available to hospitals with greater percentages of Medicaid discharges rather than limiting funds to hospitals in municipalities with a combination of certain population and economic aspects. At a minimum, four hospitals (Norwalk, Danbury, Mid State and Windham) should be considered for the urban/distressed DSH funds.**

Even if the program parameters for urban DSH remain the same, program review recommends **the distribution formula for urban DSH should be re-configured.** Currently, the urban DSH formula only reflects the Medicaid fee-for-service population; for payment the SAGA population is not taken into consideration. Table II-13 re-calculates the payment distribution of the urban DSH appropriation for FY 06 when the

SAGA discharges are also taken into account. As the table shows, the percentages among the hospitals currently receiving urban DSH shifts when the SAGA volume is considered.

Table II-13. Re-distribution of FY 06 DSH Funds When Considering SAGA Population.					
Hospital	**04 FFS Discharges**	**04 Discharges (w/SAGA)**	**New Percent of Discharge Total**	**New Distribution**	**Difference**
Bridgeport	1,836	2,356	10.0481	$3,170,205	(142,491)
Hartford	2,612	3,558	15.1746	$4,787,602	74,769
New Britain	1,036	1,422	6.0647	$1,913,426	44,171
St. Francis	2,210	3,411	14.5477	$4,589,800	602,296
St. Mary's	866	1,243	5.3013	$1,672,566	110,042
St. Raphael	1,349	1,843	7.8602	$2,479,919	45,918
St. Vincent's	1,469	1,732	7.3868	$2,330,558	(319,960)
Stamford	1,409	1,669	7.1181	$2,245,786	(296,474)
Waterbury	990	1,342	5.7235	$1,805,779	19,521
Yale- New Haven	3,709	4,871	20.7745	$6,554,359	(137,792)
TOTAL	**17,486**	**23,447**	100	**$31,550,000**	
Source: LPRIC Analysis					

As noted earlier, DSS is authorized within Connecticut's state Medicaid plan to receive federal matching funds under the DSH Medicaid program for payments made to hospitals for various low-income populations. DSS also receives matching funds for payments made to hospitals providing treatment services to low-income persons determined eligible for assistance under SAGA.[8] (Table II-14 reflects Connecticut's annual DSH report for 2005.)

Given that DSS receives matching federal funds for payments made for SAGA clients and that the payment to cost ratio for SAGA patients is extremely low supports the conclusion that the DSH distribution formula should be reconfigured to further assist hospitals that serve a disproportionate share of SAGA clients.

Outpatient services. As mentioned earlier, hospitals receive a substantial amount of revenue from outpatient services. Medicaid paid hospitals approximately $238 million for outpatient services in FY 05. This reflects about 48 percent of the Medicaid managed care hospital payments and a third of the fee-for-service payments.

A closer examination reveals that outpatient services constitute more than 60 percent of total payments at five hospitals. Comparing populations, Medicaid managed care provides more than 60 percent of payments for outpatient services at 12 hospitals while three hospitals receive more than 65 percent of outpatient payments for Medicaid fee-for-service.

[8] DSS also receive matching federal funds for DSH monies made to the Connecticut Children Medical Center (CCMC) and uninsured or underinsured children under the jurisdiction of the Commissioner of the Department of Children and Families (DCF).

Table II-14. Department of Social Services FY 05 DSH Annual Report							
HOSPITAL	SAGA & DCF	UCC Program	DMHAS SAGA	CHN Hosp O/P & Ancillaries	URBAN	CCMC	TOTAL DSH
Backus	$1,078,985	$2,400,051	$596,622	$6,533			$4,082,191
Bradley	$0	$0	$0	$0			$0
Bridgeport	$3,388,612	$4,334,767	$494,108	$51,962	$3,218,952		$11,488,401
Bristol	$863,670	$909,539	$353,153	$965			$2,127,328
CCMC	$99,924	$0	$0	$0		$6,750,000	$6,849,924
Danbury	$1,802,634	$3,119,747	$490,181	$69,250			$5,481,811
Day Kimball	$594,327	$1,086,733	$128,486	$0			$1,809,545
Dempsey	$1,374,215	$0	$285,858	$0			$1,660,073
Essent/Sharon	$122,057	$237,402	$0	$2,780			$362,239
Greenwich	$149,955	$1,349,888	$10,557	$9,272			$1,519,672
Griffin	$11,394	$634,696	$0	$0			$646,090
Hartford	$4,854,609	$7,215,639	$1,767,586	$198,324	$4,641,049		$18,677,207
Hungerford	$539,877	$907,863	$593,652	$31,737			$2,073,129
Johnson Memorial	$418,165	$414,228	$415,558	$0			$1,247,951
Lawrence Memorial	$1,291,277	$2,490,216	$183,119	$8,830			$3,973,442
Manchester	$874,125	$1,015,020	$639,639	$28			$2,528,812
Mid State	$1,222,191	$1,449,168	$144,665	$308			$2,816,332
Middlesex	$1,197,304	$1,911,608	$513,229	$168			$3,622,308
Milford	$416,983	$248,135	$0	$0			$665,118
New Britain General	$2,342,237	$1,855,117	$647,213	$93,395	$1,876,978		$6,814,939
New Milford	$345,526	$333,621	$8,946	$737			$688,830
Norwalk	$1,705,231	$2,518,880	$377,730	$4,164			$4,606,004
Rockville	$419,566	$417,097	$0	$0			$836,663
St. Francis	$3,513,196	$4,742,209	$1,204,132	$163,497	$3,989,826		$13,612,859
St. Mary's	$2,054,675	$1,025,124	$422,757	$0	$1,639,072		$5,141,627
St. Raphael	$2,783,022	$2,873,242	$331,813	$118,570	$2,318,560		$8,425,206
St. Vincent's	$2,278,105	$2,870,692	$47,815	$24,281	$2,321,704		$7,542,597
Stamford	$1,458,854	$3,629,579	$413,797	$36,590	$2,586,771		$8,125,590
Waterbury	$1,751,561	$2,033,757	$615,036	$19	$1,670,202		$6,070,575
Windham	$1,185,457	$530,066	$17,515	$184			$1,733,222
Yale-New Haven	$7,707,888	$9,920,920	$1,106,818	$66,272	$7,286,886		$26,088,785
TOTAL	**$47,845,623**	**$62,475,000**	**$11,809,983**	**$887,866**	**$31,550,000**	**$6,750,000**	**$161,318,472**
Source: Department of Social Services							

The correlation between the amount of outpatient payments and outpatient services is unknown because comprehensive utilization data is not collected Nevertheless, it is clear that *certain hospitals rely heavily on outpatient revenue and presumably provide a great deal of outpatient services to their communities*. Earlier, program review recommended Medicaid outpatient rates be adjusted annually noting that increases would especially help hospitals that receive much of their revenue from outpatient services. In addition, the program review committee recommends **the state establish a disproportionate share fund available to hospitals serving large percentages of Medicaid clients on an outpatient basis.**

Outpatient services at a hospital often supplement medical services in the community or in some cases may be the only access available in a community. As such, program review believes financial recognition of this hospital service should be established. Without utilization data, the exact level of outpatient services is unknown. However, the enhanced monitoring of utilization by DSS and DHMAS recommended earlier should provide information as the potential basis for distribution of funds.

Federal DSH reporting requirements. The Medicare Prescription Drug, Improvement, and Modernization Act of 2004 (MMA) implemented new reporting and audit requirements for the DSH program. For fiscal years beginning in 2004, each state is required to submit to CMS an annual report that identifies each hospital that received DSH payments for the preceding fiscal year and the amount of DSH payments made to the hospital. CMS may also obtain other information deemed necessary to ensure the appropriateness of DSH payments for the preceding year.

For fiscal years beginning in 2004, each state is also required to submit to CMS an annual independently certified audit that verifies the amount by which hospitals have reduced their uncompensated care costs as a result of claimed DSH expenditures. This comprehensive audit is to include verification of payments to hospitals, uncompensated care costs, hospital-specific limits, and adherence to documentation requirements.

Uncompensated Care

Connecticut hospitals must, pursuant to federal law, serve any person who presents with an emergency medical condition, regardless of insurance status or ability to pay.[9] As a result, hospitals typically end up providing a substantial amount of free or discounted care. To fund uncompensated care, hospitals must either be able to charge paying patients more (that is, shift costs) or assume the loss.

The discussion below focuses on the two components of uncompensated care – free care and bad debts. In addition, the use of free bed funds available at some Connecticut hospitals is also discussed.

[9] The Emergency Medical Treatment and Active Labor Act was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1986.

Free care and bad debts. Each Connecticut hospital must file a copy of its current policies relating to free care and bad debts with OHCA. Free care is the provision of service by a hospital knowing in advance there will be no payment by the patient.[10] (Courtesy discounts, contractual allowances, and charges for health care services provided to employees are not included under the definition of free care.)

Bad debt is the cost of providing care for which the hospital expects to obtain reimbursement but learns after the fact that it will not receive payment. Bad debts are considered deductions from revenues if, after reasonable collection efforts, it is determined that the accounts are uncollectible.

Each hospital must annually file with OHCA information regarding the amount of free care given as well as the total amount of bad debts written off during the previous year. OHCA may annually review each hospital's level of uncompensated care, which includes free care and bad debts, to assure that an appropriate level of care is provided to the indigent and the uninsured, but when appropriate, collection efforts have taken place.

Table II-15 shows the total amount of uncompensated care for each hospital reported in FY 05. As the table shows, the total uncompensated care charges for all hospitals in FY 05 was over $388 million ranging from slightly over $900,000 at Bradley to close to $42 million at Hartford Hospital. The statewide hospital median for uncompensated care at the charge level was $9.8 million.

Table II-15 also breaks down each hospital's total uncompensated care into its two components of: 1) free care; and 2) bad debt. As the table illustrates, bad debt accounted for 72 percent of total statewide uncompensated care. For FY 05, the percent of bad debt at each hospital ranged from 28 percent at Greenwich to 97 percent at New Britain. *With the exception of Greenwich Hospital, every acute care hospital's overall bad debt outweighed free care.* Statewide, the median percentage for bad debt was 76 percent with a median bad debt total of $7 million.

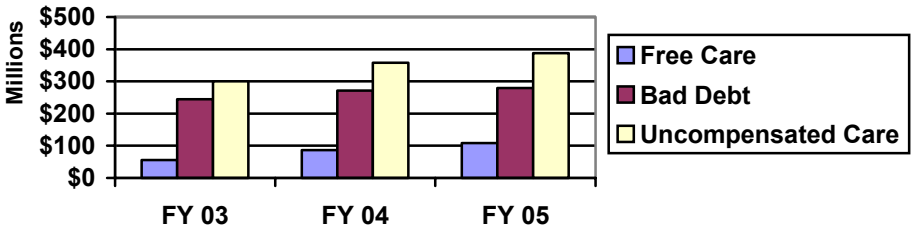
The total amount of free care ranged from approximately $32,000 at Bradley to $17 million at Hartford Hospital. The percentage of free care ranged from three percent at New Britain to 72 percent at Greenwich. The statewide median percentage of free care was 24 percent and the median amount of free care was $1.6 million.

[10] Specifically, OHCA regulations define free care as "the difference between the amount of expected reimbursement from charity patients, as defined by a hospital board approved free care policy approved by OHCA, for hospital services rendered, and the amounts of the hospital's published charges for such services." Bad debt is defined as "the uncollectible accounts receivable of the hospital relating to patients from whom reimbursement was expected."

Table II-15. Distribution of Free Care, Bad Debt, and Total Uncompensated Care in FY 05.					
HOSPITAL	FY 05 Free Care	% of Hospital Total	FY 05 Bad Debt	% of Hospital Total	FY 05 Total Hospital Uncompensated Care
Backus	$2,535,009	25	$7,476,665	75	$10,011,674
Bradley	$32,174	4	$878,461	96	$910,635
Bridgeport	$8,920,434	33	$18,489,055	67	$27,409,489
Bristol	$688,672	9	$6,896,262	91	$7,584,934
CCMC	$420,544	17	$2,025,390	83	$2,445,934
Danbury	$8,121,149	42	$11,347,701	58	$19,468,850
Day Kimball	$759,601	17	$3,663,413	83	$4,423,014
Dempsey	$752,944	22	$2,723,435	78	$3,476,379
Essent/Sharon	$600,122	25	$1,819,158	75	$2,419,280
Greenwich	$11,932,073	72	$4,621,730	28	$16,553,803
Griffin	$2,094,321	25	$6,415,560	75	$8,509,881
Hartford	$17,123,304	41	$24,861,932	59	$41,985,236
Hungerford	$566,431	29	$1,381,066	71	$1,947,497
Johnson Memorial	$431,525	9	$4,416,509	91	$4,848,034
Lawrence Memorial	$1,898,766	14	$11,496,698	86	$13,395,464
Manchester	$1,281,564	24	$4,169,968	76	$5,451,532
Mid State	$917,479	11	$7,080,686	89	$7,998,165
Middlesex	$2,253,481	18	$10,361,301	82	$12,614,782
Milford	$371,489	11	$2,869,952	89	$3,241,441
New Britain General	$327,997	3	$12,034,382	97	$12,362,379
New Milford	$1,173,949	36	$2,095,138	64	$3,269,087
Norwalk	$5,122,306	32	$10,641,421	68	$15,763,727
Rockville	$715,770	24	$2,298,807	76	$3,014,577
St. Francis	$7,030,166	36	$12,624,331	64	$19,654,497
St. Mary's	$1,175,197	12	$8,670,440	88	$9,845,637
St. Raphael	$3,901,407	21	$14,297,995	79	$18,199,402
St. Vincent's	$5,231,883	26	$14,634,541	74	$19,866,424
Stamford	$6,566,676	19	$28,875,611	81	$35,442,287
Waterbury	$1,620,443	12	$12,447,806	88	$14,068,249
Windham	$1,625,369	33	$3,365,153	67	$4,990,522
Yale-New Haven	$12,560,367	34	$24,404,596	66	$36,964,963
TOTAL	**$108,752,612**	28%	**$279,385,163**	72%	**$388,137,775**
Median	**$1,620,443**		**$7,080,686**		**$9,845,637**
Source: LPR&IC Analysis					

Reported bad debt and free care and total uncompensated care since FY 03 are depicted in Figure II-1. As the figure shows, total uncompensated care has grown since FY 03 with considerable growth in both free care and bad debt. *Overall, there has been a 29 percent increase in total uncompensated care between FYs 03 and 05 with bad debt increasing 14 percent and free care almost doubling (96%) during the same time period.*

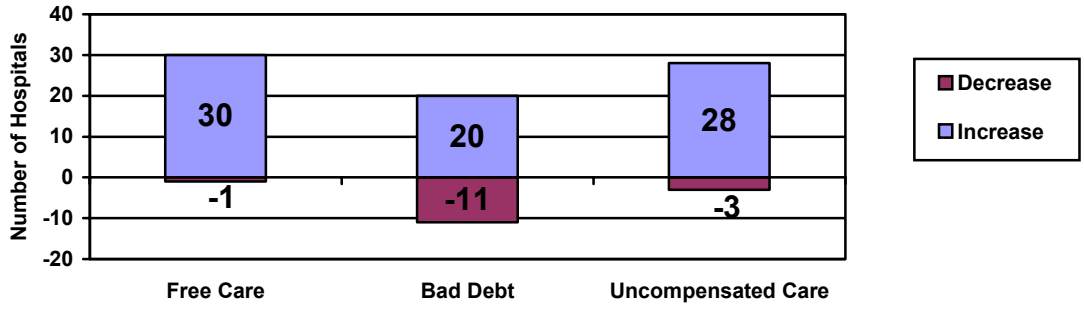
Figure II-1. Free Care, Bad Debt, Uncompensated Care: (FYs 03-05)



Source: LPR&IC Staff Analysis

An examination of the increase/decrease percentage change in the total amount of free care, bad debt, and uncompensated care between FY 03 and FY 05 is presented in Figure II-2. Uncompensated care at three hospitals has decreased since FY 03 with a 33 percent decrease at Connecticut Children's Medical Center. During this same time period, 28 hospitals witnessed an increase in uncompensated care including 21 hospitals with increases ranging from slightly less than one percent up to 50 percent. Seven additional hospitals experienced an increase of uncompensated care of more than 50 percent with two hospitals (Bradley and New Milford) seeing an increase of their total uncompensated care exceed 100 percent.

Figure II-2. CT Hospitals with Increase and Decrease in Free Care, Bad Debt, and Uncompensated Care (FYs 03-05)



Source:LPR&IC Staff Analysis

The amount of free care increased in all but one hospital (Bristol) between FYs 03-05. Almost all the hospitals experienced significant growth in the level of free care. Sixteen of the 30 hospitals had free care levels that more than doubled. Between FYs 03 and 05, 20 hospitals also saw an increase in bad debt. However, 11 hospitals experienced a decline in reported bad debt. (The total amount of free care, bad debt, and uncompensated care for each individual hospital since FY 03 is detailed in Appendix C.)

Cost of uncompensated care. As noted earlier, charges for uncompensated care in FY 05 totaled $388 million. However, the actual cost to hospitals is calculated by multiplying uncompensated care charges by the ratio of cost to charges for all payers. In FY 05, Connecticut's statewide uncompensated care costs among acute care hospitals totaled more than $173 million. This represented 2.8 percent of total hospital expenses. *A large portion (47%) of the total cost of uncompensated care for the state was borne by the nine urban hospitals in Hartford, New Haven, Bridgeport, and Waterbury.*

Table II-16 shows the uncompensated care costs as a percent of total operating expenses statewide since FY 03. As the table shows, both uncompensated care costs and total operating expenses have increased since FY 03. However, *uncompensated care costs as a percentage of total expenses have remained relatively the same.*

Table II-16. Uncompensated Care Costs as Percentage of Total Expenses.

STATEWIDE	FY 03	FY 04	FY 05
Uncompensated Care Costs	$148,827,480	$164,312,115	$173,340,070
Total Operating Expenses	$5,308,480,106	$5,682,065,439	$6,050,276,212
Uncompensated Care % of Total Expenses	2.80	2.89	2.86

Source: LPR&IC Analysis

Summary. For almost every hospital in the state, bad debt far outweighs free care as a percentage of uncompensated care. However, free care has significantly increased (96%) since FY 03. A large portion of uncompensated care is seen in the state's major cities. To put these figures in context, it may be reasonable to assume that during strong economic times higher levels of employment would translate into lower levels of free care. However, increasingly higher co-pays and deductibles imposed by many employers may actually increase bad debt and/or the need for reduced cost care.

The program review committee asked the Connecticut Hospital Association if it would be possible to identify how much of a hospital's bad debt is the result of insured individuals unable to meet deductibles. However, this type of information is not routinely captured or reported by hospitals.

Free Care and Reduced-Cost Reporting Requirement

Since 2003, state law requires hospitals to file more detailed information on their free care and reduced care with the Office of Health Care Access. Specifically, state law requires that hospitals file annually with OHCA their policies on free or reduced-cost services to the indigent and their debt collection practices. State law also requires hospitals to report: 1) the number of applicants for free care and reduced-cost care, 2) the number of approved applicants, and 3) the total and average values of free and reduced-cost care provided. The following is a discussion of the program review analysis of this information.

Hospital financial assistance policies. State law prohibits hospitals that provide services to an uninsured patient from collecting from the patient more than the cost of providing the services. State law defines an uninsured patient as a person with income at or below 250 percent of the federal poverty level who: 1) has been denied eligibility for health care coverage under Medicaid or the state administered general assistance program for failure to satisfy income or other eligibility requirements; and 2) was not eligible for hospital service coverage under Medicare, Champus, Medicaid, or any health insurance program of another nation, state, or U.S. territory or commonwealth, or any other government, or private health, accident insurance, or benefit program.

In 2006, that income threshold -- 250 percent of the federal poverty level -- is $24,500 annually or $2,042 monthly for an individual. Some hospitals hoping to assist uninsured individuals obtain coverage may hire or designate an employee to assist patients with the various application processes or in some cases even compensate the state to have a DSS Medicaid eligibility worker on location.

The process of identifying patients who may be eligible for a government program or who otherwise may need some level of free or reduced cost care is not simple. To qualify for financial assistance from a hospital, patients are often asked to complete and return forms, submit proof of income, and provide a variety of other documentation. This process can be long and cumbersome, and patients, sometimes indigent, may forget, give up, or get lost in the process. Consequently, some services that could have been classified as charity care are categorized as bad debt when the hospital receives no payments.

The program review committee examined the most recent free bed and charity care policies filed at OHCA. A review of hospital policies filed with OHCA found that eligibility and application requirements vary but all hospitals utilize a percentage of the federal poverty level to determine patient eligibility for hospital financial assistance.

All hospitals expect all third party resources to be exhausted before considering patients for financial assistance or free bed funds. Full charity care is available at all hospitals to patients with household incomes at 100 percent of the federal poverty level. Almost all the hospitals have developed a sliding-fee scale that specifies different percentage discounts from charges depending on patients' household income; for example, free care for patients is provided at a specified percentage of FPL with lesser discounts for patients with progressively greater means.

In general, hospital financial assistance and availability of free bed funds start at 250 percent of the federal poverty guidelines, which is the basis for the statutory definition of an uninsured individual. As Table II-17 shows, Connecticut acute care hospitals offer financial assistance to patients with household incomes that fall in ranges up to 500 percent of the federal poverty level. A few hospitals (St. Raphael, Stamford, and Yale-New Haven) also extend discounts to patients whose income may be relatively high, but whose hospital bills exceed a certain proportion of their annual household income or assets. One hospital (Norwalk) provides a 15 percent reduction to patients at any income level if they express difficulty paying bills. However, the reduction is not available for co-pays, deductibles, or government programs. Nine

hospitals specifically mention the reduction of charges to cost for uninsured individuals pursuant to state law.

Table II-17. Summary of Current Hospital Policies on Financial Assistance.	
Policy	**Number of Hospitals**
Eligible for financial assistance, including free beds, if family income is at or below 250% of federal poverty guideline	31
Eligible for sliding scale discount if income is above 250%	9
Eligible for sliding scale discount if income is at or below 300%	1
Eligible for sliding scale discount if income is at or below 350%	3
Eligible for sliding scale discount if income is at or below 400%	4
Eligible for sliding scale discount if income is at or below 500%	1
Specifically mentions reduction of charges to cost for uninsured individuals pursuant to state law	9
Source: LPR&IC Analysis	

Free care applicants. Table II-18 provides a summary of the number of free care applicants, the number and percentage approved for free care, as well as the total free care charges and costs reported by hospitals in FY 05. As the table shows, there were more than 67,000 applicants statewide for free care in FY 05. Of this number, 86 percent were approved for free care.

The free care applicant pool ranged from 60 at Bradley to over 14,000 at St. Francis. The approval rates ranged from 18 percent at New Britain to 100 percent at three hospitals (Greenwich, Waterbury, and St. Mary's). Overall, 17 hospitals approved 90 or more percent of free care applicants. Six hospitals had approval ratings of less than 40 percent.

Table II-18. Number and Approval Rates of Free Care Applicants in FY 05					
STATEWIDE	**Free Care Applicants**	**Approved Applicants**	**% Approved**	**Total Free Care Charges**	**Total Free Care Costs**
TOTAL	**67,678**	**58,500**	**86%**	**$108,752,614**	**$50,377,094**
Range					
Low	60	23	18%	$32,173	$14,700
High	14,442	14,233	100%	$17,123,304	$8,849,324
Median	924	553	91%	$1,622,906	$579,146
Source: LPR&IC Analysis					

As discussed earlier, the free care *charges* reported in FY 05 ranged from slightly over $32,000 to approximately $17 million. However, total free care *costs* ranged from about $15,000 to close to $9 million. Statewide, the cost of free care totaled $50.3 million with a median cost per hospital of $579,146.

Charity care applicants. As noted previously, courtesy discounts, contractual allowances, and charges for health care services provided to employees are not included under the definition of free care and not included in the calculation of disproportionate share payments. These items are typically reported under the broader term of charity care. The program review

committee examined OHCA reports collected under the provisions of P.A. 03-266 and found that 16 hospitals did not treat or report any items as charity care in FY 05.

According to OHCA, some of the smaller hospitals may, in fact, not have charity care items beyond free care. However, certain hospitals that do not report some of these items (e.g. employee discounts) as charity care do report them as allowances in their audited financial statements which OHCA reconciles. OHCA states that this does not affect any calculations or provide any incentive or benefit. Charity care items as defined by OHCA are not detailed in the reported allowances. Therefore, further analysis for these hospitals was not possible.

Table II-19 lists the hospitals that did report charity care to OHCA in FY 05. As the table presents, 15 hospitals reported providing charity care beyond the OHCA definition of free care. This charity care totaled $40.8 million in hospital charges and $17.7 in hospital costs. Based on these reports, 29,000 additional individuals received charity care. *The vast majority of the charity care was reported by three hospitals (Bridgeport, Hartford, and Yale-New Haven).*

Table II-19. Charity Care Charges and Costs Among Hospitals in FY 05

HOSPITAL	Charity Care Charges	Charity Care Costs
Backus	$384,351	$208,164
Bridgeport	$15,234,566	$5,934,435
Bristol	$56,637	$56,891
CCMC	$803,893	$490,867
Greenwich	$678,925	$306,060
Hartford	$5,379,192	$2,779,966
Lawrence Memorial	$311,064	$160,301
New Britain General	$286,752	$116,684
New Milford	$660,907	$300,779
Rockville	$27	$12
St. Mary's	$443,803	$193,720
Stamford	$12,324	$5,600
Waterbury	$539,919	$192,967
Windham	$21,393	$406,988
Yale-New Haven	$15,995,038	$6,623,545
Total	**$40,808,791**	**$17,776,979**
Source: LPR&IC Analysis		

Bed funds. In addition to free or charity care, many hospitals have bed funds available to certain qualified patients. By OHCA regulation, hospital bed funds refer to "gifts of money, stock, other financial instruments, or other property made to establish a fund to provide medical care to patients at a hospital. A fund may be established by gift, bequest, subscription, solicitation, dedication, or any other means."

State law requires information on available bed funds to be posted conspicuously in public places of hospitals where patients are admitted. This includes the admissions office, emergency room, social services department, and patient accounts or billing office. The information must be in plain language and statutorily required to be in 48 to 72 point type. The

information must include notification that bed funds exist and the contact person for fund applications. The notice must be in English and Spanish. As with free care, hospitals with bed funds must maintain and annually compile information on applications for the funds. The committee saw such postings in the various hospitals visited during the course of the study.

Table II-20 lists information regarding hospital bed funds in FY 05. Nineteen hospitals reported bed fund activity in FY 05. The hospitals had a total applicant pool of approximately 12,900 individuals with 34 percent approved.

Table II-20. Bed Fund Activity Reported Among Hospitals in FY 05.

HOSPITAL	Bed Fund Applicants	Applicants Approved	% Approved	Total Bed Fund Charges	Total Bed Fund Cost	FY 05 Ending Balance of Available Bed Funds
Stamford	997	9	1	$436,257	$198,210	$557,531
St. Francis	2,183	27	1	$227,498	$118,049	$781,337
Lawrence Memorial	1,242	48	4	$50,831	$26,239	$1,054,234
Middlesex	3,310	446	13	$150,840	$68,975	$1,742,023
Mid State	197	37	19	$119,283	$60,620	$125,000
New Britain General	459	116	25	$286,752	$116,683	$732,973
Backus	423	147	35	$440,434	$238,539	$125,000
Manchester	597	244	41	$775,000	$356,500	$618,392
Bristol	35	25	71	$11,928	$5,437	$1,410,387
Hartford	614	465	76	$2,151,583	$1,111,938	$60,205,406
Greenwich	291	238	82	$1,341,387	$604,697	$1,123,000
Waterbury	804	803	100	$541,661	$193,590	$13,924,016
Bridgeport	295	295	100	$178,124	$69,379	$12,066,320
CCMC	1	1	100	$2,008	$1,226	$75,211
Griffin	6	6	100	$8,384	$2,971	$231,897
Hungerford	43	43	100	$28,375	$16,136	$265,004
St. Mary's	4	4	100	$21,755	$9,496	$0
St. Raphael	31	31	100	$111,176	$42,592	$716,635
Yale-New Haven	1,373	1,373	100	$4,721,870	$1,955,326	$25,533,147
TOTAL	**12,905**	**4,358**	**34**	**$11,605,146**	**$5,196,603**	**$121,287,513**
RANGE Low	1	1	1%	$2,008	$1,226	$0
High	3,310	1,373	100%	$4,721,870	$1,955,326	$60,205,406
Median	423	48	76%	$178,124	$69,379	$732,973

Source: LP&RIC Analysis

The statewide median number of bed fund applicants was 423. The approval rate ranged from one to 100 percent with a median approval rate of 76 percent. Eight hospitals approved all applicants for their bed funds. Charges for bed funds totaled $11.6 million while costs were closer to $5.2 million.

Table II-20 also provides each hospital's reported ending balance for FY 05 of donations and funds restricted for indigent care/free beds. As the table shows, the statewide ending balance for these funds in FY 05 was over $121 million and the FY 05 expenditures based on charges from these funds were $11.6 million. (Three additional hospitals - St. Vincent's, Rockville, and Windham - reported available ending balances in FY 05 but had no corresponding expenditures or applicants.)

Based on the analysis, *there appears to be a number of hospitals with a substantial balance in bed funds. However, the restrictions placed on many of the bed funds are sometimes a condition of the gift or donation (e.g. available to members of certain groups). As a result, the use of bed funds for several hospitals is limited.*

Further review of the free bed expenditures revealed that almost all of the hospitals providing free care funds receive their compensation on charges. According to OHCA, there is no rule or policy regarding this practice. The committee questioned whether hospitals should compensate themselves on a charge level for individuals who are determined to be in need. However, given the limited access to bed funds for most hospitals, it seems prudent for hospitals to follow this practice if so desired.

Summary. A review of the information that is currently collected by OHCA reveals the need for further comprehensive analysis. According to OHCA, *the information submitted by hospitals on the levels of free and reduced cost care pursuant to P. A. 03-266 is collected for the sole purpose of satisfying the statutory reporting requirements.* The information submitted by each hospital is reviewed by the OHCA analyst assigned to examine the individual hospital's finances. However, *OHCA does not conduct a statewide overview or comparison of this particular hospital reporting requirement nor make any determinations about the implementation of hospital policies or other mandated activities.*

Through its examination of this information, the committee found at least one example of a hospital reporting erroneous information (i.e., number of applications as opposed to applicants), which was subsequently corrected. Discussions with OHCA staff revealed that the mistake was due in part to the newness of the reporting requirement and a misunderstanding by the hospital of what was required. The committee acknowledges the recent implementation of this reporting requirement and the need for time to remedy any learning curve. However, it is not clear to the committee that a process is in place that would have otherwise found the misreporting for this item since no analysis of this particular information is performed and it is collected solely to satisfy the statutory reporting requirement. The program review committee believes *if the information collected pursuant to Public Act 03-266 is to remain a mandatory reporting requirement, then the data should be used towards some purpose or measure. Furthermore, all hospital data filed with OHCA should be routinely verified for accuracy and consistent reporting among hospitals.*

Program review researched the legislative history for this statutory reporting requirement and found no stated legislative intent. The changes appear to have evolved from concerns regarding aggressive billing and collection practices at certain hospitals. OHCA is reporting, as

mandated, on the number of applicants and approvals for free and reduced cost charges and care. However, the committee believes *OHCA should be more than central repository for health care data.*

As part of its mission, OHCA gathers, verifies, analyzes, and reports on a wide range of hospital financial data for use by health care policy decision-makers. Currently, OHCA produces a number of publications regarding various aspects of health care policy. Information in these publications includes hospital expenses and revenues, uncompensated care volumes, and other financial data. OHCA also reports on data related to hospital and health care utilization. This published information is the result of OHCA analyzing audited financial statements, hospital forms, schedules, and attachments submitted by the individual hospitals. However, the committee believes *OHCA should extend its analysis to a more comprehensive level.*

For example, one of OHCA's existing publications is an annual report on the financial status of Connecticut's acute care hospitals. The report provides a profile of each hospital on a number of financial and utilization measures. There is a broad statewide overview provided in the beginning of the report and a number of appendices containing graphics and tables. However, any comparisons among hospitals or conclusions regarding individual hospitals are left to the reader to determine. The committee believes *OHCA should assume a more advisory role to policy makers on health care issues.*

Therefore, the program review committee recommends **OHCA prepare a supplemental report that summarizes all information currently filed by hospitals. At a minimum, OHCA should conduct analysis that compares hospitals on the basis of size and/or geographical location that leads to conclusions and potential recommendations for policy makers. In particular, OHCA's review for the supplemental report should include, but not be limited to:**

- **the general provisions of each hospital's policies regarding free and charitable care including bed funds;**
- **the number and approval rates of free and reduced care applicants;**
- **access, use, and available level of bed funds; and**
- **analysis of charges and costs for free and reduced care.**

As part of this expanded review, OHCA may want to consider requesting further detailed information. For example, OHCA may wish to explore whether additional information may gauge the impact of high deductibles or premiums on a hospital's bad debt. However, OHCA reports should contain more than a compilation of data. Further data analysis would allow OHCA to fully carry out its mission of monitoring the state's health care delivery system, identifying areas of potential need, and formulating appropriate solutions, and lead to better coordination of state policy and actions to control cost and increase quality. Finally, in addition to informing policymakers, this supplemental report may educate consumers on making their health care decisions.

Chapter III

Hospital Utilization in Connecticut

Emergency Room Utilization

Connecticut residents' use of the emergency room is high and the increase in usage has been substantial. Program review committee members had expressed concern over the rising ER use, and asked staff to examine this area.

In FY 03 there were a 1.38 million ER visits statewide, and in FY 05, almost 1.45 million – more than 75,000 additional visits in two years, about a 5.5 percent increase. There were about 38.3 ER visits per 100 residents nationwide and about 40.6 ER visits per 100 in Connecticut, about 5 percent higher. The breakdown by payer group is shown in Table III-1 below.

Table III-1. Connecticut Emergency Room Use by Payer Group FY 05

Payer Group	ER Visits per 100
Private Payer	21.4
Medicare	56.2
Medicaid FFS	99.6
Medicaid Managed Care	77
SAGA	155.5
Uninsured	37.5
Overall ER Visits per 100	40.6

Source: Connecticut Hospital Association Data

As noted in the table, all government payers had considerably higher emergency room utilization than the private payer group, the uninsured, or the overall average. These numbers mimic data from national studies showing that emergency room use is growing and that those insured by government payers have substantially higher use. A couple of major reasons appear to contribute to the trend. The payment structure of government payers, especially Medicaid and SAGA, limits access to other care, with private providers unwilling to take Medicaid clients because of low reimbursement. Under the SAGA program, no private medical community access is provided. Community Health Network (CHN-CT), a managed care organization, works through the federally qualified health centers, which are under contract to provide SAGA clients' community medical services. With limited access to other providers, these clients go to the emergency room.

There also is no financial deterrent to the client and, as discussed in the prior chapter, a limited financial drawback to the Medicaid MCO for their enrollees seeking emergency room care. Many privately insured persons have better access to other care – private physicians, pediatric groups, and the like. These privately insured clients often incur substantial co-pays for ER visits – the Connecticut Insurance Department allowable maximum co-pay for an ER visit is $150. With no financial deterrent on the individual Medicaid client or on the Medicaid managed

care plan against using the ER for primary care, and limited or no access to care in other settings, it is not surprising that SAGA and Medicaid client use of the ER is high.

A recent analysis by the Office of Health Care Access shows the rise in the use of the ER by payer group, and, as the table indicates, for each payer category, the percentage of inpatient discharges that began in the ER has grown. In fact, in FY 05 more than half of inpatient stays begin in the emergency room (if newborns were taken out of the denominator, the percentage would be even higher).

Table III-2: Connecticut Emergency Room Use – FY 01 and FY 05

	Fiscal Year 2001			Fiscal Year 2005		
	Percent of all stays billed to each payer	Percent of stays beginning in the ER billed to each payer	Percent of each payer's hospital stay that begin in the ER	Percent of all stays billed to each payer	Percent of stays beginning in the ER billed to each payer	Percent of each payer's hospital stay that begin in the ER
Medicare	39%	54%	62%	40%	54%	68%
Medicaid	15%	14%	41%	17%	15%	44%
Other Public	1%	1%	25%	1%	1%	31%
Commercial	42%	28%	30%	39%	27%	34%
Uninsured	3%	3%	49%	3%	3%	63%
	100%	100%	44%	100%	100%	54%
Source: Office of Health Care Access						

Emergency room volume impact by hospital. Program review examined each hospital's volume of ER visits as a percent of all ER visits statewide and found that four hospitals handle about one-quarter of all ER visits in the state:

Table III-3. Emergency Room Use—Top Hospitals

Hospital	Percent of total
Yale-New Haven	7.37%
Lawrence and Memorial	5.82%
Middlesex	5.77%
Hartford	5.52%
Total %	24.48%
Source: LPR&IC Analysis	

Because some of the largest hospitals (e.g., St. Francis, St. Raphael, Bridgeport) were not among the top hospitals for ER volume, the committee examined the distribution of ER volume further. The committee used the ratio of a hospital's ER volume to the total ER volume and compared that to the ratio of staffed beds that a hospital has of all hospital beds statewide (as a proxy for capacity). The results showed that there is a correlation (+.71) between the two measures, but there are also some imbalances. Program review subtracted the percentage of staffed beds from the percentage of total ER visits for each hospital and found gaps on either side -- those with a greater percentage of beds than their ER visits of the total, and those with a

greater percentage of ER visits than beds of total beds. Table III-4 shows the five hospitals with the greatest gaps on either side.

Table III-4. Comparison of the Gap in Distribution of Beds and ER Visits Among Hospitals			
Hospitals with a Greater percentage of ER visits Than Staffed Beds		**Hospitals with a greater percentage of staffed beds than ER visits**	
Hospital	Gap -- % More ER visits	Hospital	Gap-- % More Beds
Middlesex	3.34	Hartford	5.19
Mid-state	2.73	Yale	4.62
Lawrence and Memorial	2.37	St Francis	3.65
St. Mary's	2.01	St. Raphael	2.91
Danbury	1.28	Stamford	1.45
Source: LPR&IC Analysis			

While certainly the larger urban hospitals are handling a greater percentage of ER visits of the total number as shown in Table III-3, it is worth noting that the smaller urban hospitals see a greater percentage of the volume than their bed size would indicate. The high volume of ER visits to these smaller urban hospitals may indicate they are the only hospitals for a wide service area so that in an emergency local residents go to the closest hospital, whereas for a planned hospital procedure, a patient would travel to one of the larger urban hospitals.

Admit rates. On average, only about 15 percent of patients who go to the ER are admitted for inpatient care. Program review examined the percentage of patients who come to the ER who are admitted by hospital and the top seven hospitals (above 19 percent are admitted) and bottom (below 10 percent are admitted) are reported in Table III-5.

Table III-5. Comparison of Emergency Room Admit Rates			
Highest % Admit of ER Visits		**Lowest % Admit of ER Visits**	
St. Raphael	27.5%	Mid-State	8.8%
Yale-New Haven	21%	CCMC	9.2%
St. Francis	20.8%	Middlesex	9.3%
Stamford	20%	Lawrence & Memorial	9.3%
Norwalk	19.7%	New Milford	9.5%
Day Kimball	19.6%		
St. Vincent	19.6%		
Statewide Average	**15.3%**	**Statewide Median**	**14.5%**
Source of Data: Office of Health Care Access			

It is interesting to note that three of the five hospitals – Mid-state, Middlesex, and Lawrence and Memorial -- with the greatest gap between the percentage of ER visits over bed ratio (Table III-4) also had the lowest admits through the ER. *This may suggest there is a dearth of access to other care in those areas and that people are seeking treatment at the ER because of that gap.*

Further, while large city hospitals do have the highest admit rates from the emergency room, it is unclear why New Haven's two hospitals have the highest admit rates, while neither Hartford or Bridgeport have more than one hospital on the list. This is especially noteworthy

since Hartford Hospital, which is not among the highest admit-rate hospitals, is a level one trauma center as is Yale-New Haven.

Program review is aware the legislature's Public Health Committee has created a study group, comprised of a broad panel of experts, to examine the issue of over-crowding in the emergency room. The committee believes the analysis above raises further questions that might be examined by that panel. Those areas, which conceivably contribute to overcrowding, include:

- *a trend of most hospital inpatient stays beginning in the emergency room. One factor might be that for scheduled procedures, Medicare and private pay patients are increasingly getting care elsewhere, and thus only using a hospital when in medical crisis.*
- *significant use of the emergency room by Medicaid and SAGA clients, suggesting that efforts to provide other access to care may not be working.*
- *a gap between where hospital beds are and where emergency room visits are occurring, placing a higher demand on emergency rooms at some smaller hospitals.*
- *lower admit rates at some of those hospitals with high ER volume, further suggesting that there might be a lack of access to other care in the region, and the population is seeking care at the ER inappropriately; and*
- *emergency room admit rates that vary tremendously by hospital, and even among hospitals in similar environments, with similar levels of ER certification.*

Program review believes the Medicaid MCO financial penalty for inappropriate use of the ER, as recommended in the previous section, may provide an incentive for MCOs to develop better preventive and primary care networks for their clients.

Medicaid Inpatient Utilization

There were approximately 420,000 total inpatient hospital stays in Connecticut in FY 05, a rate for the overall population of 12 stays per 100 residents. Medicaid clients accounted for about 70,000 of hospital stays, or about 16.7 percent of all stays. The committee reported the breakdown in inpatient stays by segments of the Medicaid population in the briefing, and it is shown in the table below.

Table III-6. Medicaid Inpatient Stays by Population – FY 05

Medicaid Inpatient Utilization By Population	Stays per 100 Enrollees
Medicaid Managed Care	12
Medicaid Fee for Service	35.4
SAGA	30.8
Source: LPR&IC Analysis	

Childbirth-related inpatient services. The program review committee asked staff at the briefing to further examine Medicaid inpatient utilization by illness or treatment category to determine what hospital treatments were being furnished. The committee examined FY 05 discharges by diagnostically related groups and found the most prevalent Medicaid categories were for labor and delivery and newborns, just as they are for the overall population. Table III-7 below shows the overall inpatient numbers as well as the number and percent of Medicaid clients categorized in those DRGs. As the table shows, inpatient stays around childbirth account for about one-third of the 70,000 Medicaid inpatient stays, and about 18 percent of all stays in the general population.

Table III-7. Utilization – Overall and Medicaid – by Prevalent Childbirth DRG Codes

Category and DRG #	Total Number	Medicaid Number	% Medicaid
Normal Newborn (DRG 391)	30,685	9,409	30.6%
Newborn with significant problems (DRG 390)	5,032	1,641	32.6%
Total newborns	**35,717**	**11,050**	**30.9%**
Labor and Delivery Categories	**Total Number**	**Medicaid Number**	**% Medicaid**
Normal Labor and Delivery without complications (DRG 373)	22,950	7,075	30.8%
Labor and Delivery with Complicating diagnosis (DRG 372)	3,568	1,175	32.9%
C-Section with complications (DRG 370)	2,741	977	35.6%
C-Section without complications (DRG 371)	10,851	3,148	29%
Total Childbirth-related DRGs	75,827	23,425	30.9%
Percent of these DRGS of all discharges and all Medicaid discharges	18%		33.5%
Source: LPR&IC Analysis			

For the most part, the childbirth-related discharges should be included in the Medicaid Managed Care population, and inpatient services paid for by Medicaid MCOs. However, the committee asked DSS to provide data on the labor and delivery charges paid by DSS under fee-for-service Medicaid. This would occur for two primary reasons: 1) when a pregnant woman was otherwise eligible for Medicaid but did not establish that eligibility (or seek care) before the third trimester; or 2) the pregnant woman could not establish eligibility for lack of some type of required documentation, including legal status. In the latter case, Medicaid FFS pays for emergency services, which would include labor and delivery, but the person is taken off the eligibility rolls the following month. Medicaid fee for service also pays for medical services for the newborn for a period of time until Medicaid eligibility is granted to the child. The DSS data indicated there were about 2,350 cases where DSS made payments for such services during the federal fiscal year ending September 30, 2006 the past FFY.

While the data in Table III-7 on all newborns under Medicaid is for FY 05, and DSS payment data is for FY 06, there is no reason the total number of Medicaid births would vary dramatically from year to year. Thus, the data indicate more than 20 percent of Medicaid labor and deliveries and newborn services are paid for under fee for service and not Medicaid managed

care. Further, it is likely that a high percentage of the 2,350 cases are because the pregnant woman was unable to document her legal status.

Other prevalent inpatient services. The next most prevalent DRG codes (after childbirth) for Medicaid and total inpatient utilization are shown in Table III-8 below. The most prevalent code for both the general and Medicaid populations is psychoses; in fact about 4 percent of all discharges and 8.5 percent of Medicaid discharges are in that one DRG.

Table III-8. Prevalent Utilization Codes – Overall and Medicaid

Behavioral Health Categories -- by DRG Number	Total Number	Medicaid Number	% Medicaid
Psychoses (430)	16,947	5,978	35.3%
Depressive Neurosis (426)	1,845	962	52.1%
Neurosis except depressive (427)	722	374	51.8%
Childhood mental disorders (431)	473	263	49.9%
Total Psychiatric DRGs	**19,987**	**7577**	**37.9%**
Other Prevalent DRG Codes	**Total Number**	**Medicaid Number**	**% Medicaid**
Pneumonia (DRG 89)	10,931	768	7%
Chronic Obstructive Pulmonary Disease COPD (DRG 88)	6,423	606	9.4%
Chest Pain (DRG 143)	7,932	979	12.3%
Heart failure and Shock (DRG 127)	10,389	549	5.3%
Surgery – lower extremity reattachment (DRG 209)	9,363	180	1.9%
Total Prevalent Psychiatric and Medical Codes	64,568	10,643	
Percent of these DRGS of all discharges and all Medicaid discharges	15.4%	15.2%	
Source: LPR&IC Analysis			

As the table shows, the Medicaid population makes up a high percentage of the discharges in the behavioral health categories but a much smaller portion of the prevalent medical DRGs. It is probably not surprising that the Medicaid population comprises a large percentage of the behavioral health discharges – DRGs 426, 427,430, and 431. A large segment of the FFS Medicaid population is eligible for Medicaid by virtue of a disability, including mental illness, and SAGA clients (also included in the Medicaid numbers) may be awaiting Medicaid eligibility based on a disability, including mental illness. If the behavioral health inpatient stays are taken as a percentage of the 34,931 FY 05 Medicaid FFS and SAGA hospital stays, those DRGs would account for about 22 percent of the stays.

Staff also examined which hospitals are treating Medicaid patients with behavioral health issues (using DRG 430). Table III-9 lists the top and bottom hospitals by percentage of all Medicaid DRG 430 stays. (CCMC is not on the list since DRG 430 is an adult code.)

Table III-9. Comparison of Medicaid DRG 430 Stays by Hospital –FY 05			
Highest %		**Lowest %**	
Hartford	17%	Greenwich	0%
Yale-New Haven	12.7%	Windham	0%
St. Francis	9.0%	Griffin	1.3%
Bridgeport	6.3%	Day Kimball	1.4%
Waterbury	5.0%	Mid-state	1.4%
Manchester	4.9%	Johnson	2.2%
Source of Data: Office of Health Care Access			

The state's two largest hospitals accounted for almost 30 percent of all Medicaid stays for psychoses, while Greenwich and Windham Hospitals accounted for no inpatient psychiatric care for Medicaid clients. Greenwich has no inpatient psychiatric unit, and Windham had no patients in that DRG for FY 05. It may be that because of the close proximity of Natchaug, a solely psychiatric hospital located in Mansfield, Windham Hospital does not receive patients needing that service.

However, noteworthy is that Manchester and Johnson hospitals account for a higher percentage of treating Medicaid psychiatric patients than either hospital's total staffed bed number or overall stays would indicate. The committee contacted both DSS and DMHAS (which pays for SAGA inpatient stays) to determine if either agency had agreements with those hospitals to provide inpatient psychiatric care for their clients, and both agencies indicated they were unaware of any arrangement.

Overall Medicaid fee-for-service and SAGA inpatient hospital costs totaled slightly more than $192 million in FY 05, or almost $5,500 per inpatient discharge. The committee could not determine what total payments are for inpatient psychiatric care or any of the most prevalent services used by Medicaid clients, as the data by DRGs lists charges only and not payments or costs. The committee believes such payment information would be very useful to DSS and DMHAS as the major payers of psychiatric care for Medicaid clients.

While the committee recognizes that Medicaid fee-for-service clients are not in managed care, state agency payers should collect and analyze payment and client utilization data for a number of reasons:

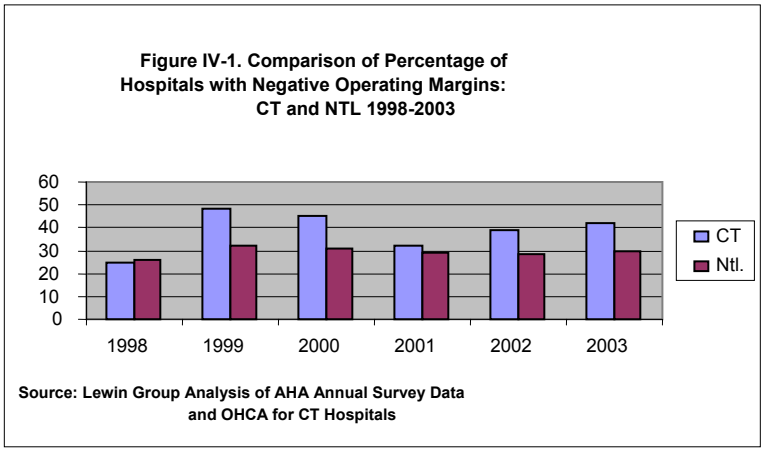
- **determine where Medicaid clients are receiving treatment, and for what conditions;**
- **determine whether inpatient care is disproportionately used by a small number of clients;**
- **ensure that other state agencies, or those under contract to serve these clients in the community, are providing needed services;**
- **conduct a cost-benefit analysis to determine if increasing rates for providers in the community, especially in the psychiatric area, may lessen the need for more intensive and expensive inpatient psychiatric care; and**
- **analyze the use of Medicaid inpatient stays for psychiatric care by hospital to determine whether outcomes (e.g., longer periods between episodes requiring hospitalization) are better at certain hospitals, especially when examined in connection with hospital costs.**

The Department of Social Services should also examine the payments being made under fee-for-service that would generally be paid for under Medicaid managed care, for example for inpatient newborn and labor and delivery services. If fee-for-service rather than Medicaid managed care is reimbursing for an increasing percentage of the costs of providing care to the Medicaid population, that information should be used when renewing contracts with the Medicaid MCOs and determining any rate increases.

Chapter IV

Connecticut's Health Care Market and Cost Containment

Connecticut's hospitals for the most part are in worse financial condition than hospitals in the rest of the nation. Figure IV-1 shows that for all but one year, Connecticut had a greater percentage of hospitals with negative operating margins than nationally. In six of the last seven years, at least 10 (more than 30 percent) Connecticut hospitals have had negative operating margins. Six hospitals are in serious financial condition, with negative margins for all of the past three years, or a large negative margin for the last year. Also, Connecticut hospitals' average operating margins are lower than those in the rest of the country.



Many factors contribute the poor financial health of Connecticut hospitals. Connecticut hospitals face higher than average energy costs and medical malpractice insurance costs are high in Connecticut. State hospitals are older than most hospitals in the rest of the country, but some Connecticut hospitals do not have adequate cash reserves and are unable to access the necessary capital to upgrade facilities.

Connecticut has a slightly higher Medicare population. Fifteen percent of state residents are Medicare enrollees compared to 14 percent nationally. Medicare reimburses hospitals in Connecticut for 97 percent of costs overall, but because Medicare pays teaching hospitals substantially more, a few hospitals are paid above their costs, while 22 hospitals in the state are not fully paid their costs.

Connecticut has a lower uninsured population than the rest of the country; but a growing percentage of residents are covered by government insurance (Medicare and Medicaid). Twenty-five percent of state residents are now insured through a government program, up from 22.8 percent just four years ago. Government insurers typically reimburse hospitals at lower levels than private payers.

The state expends a lower percentage of health care dollars on hospital care (30.8 percent) compared to the national average (36.6 percent). However, a much large portion of

state health expenditures fund long-term care (12.5 percent) compared to the national average of 7.5 percent. This funding, primarily on nursing home care for the elderly, means fewer dollars are being spent on acute and primary care.

Long-term care is mostly funded with Medicaid dollars; about $1.3 billion, or one-third of the state's Medicaid budget, is spent on nursing home care. All FY 05 state medical assistance payments for both Medicaid and SAGA populations, and disproportionate share payments totaled almost $675 million. Because such a large percentage of the state's Medicaid dollars go to long-term care, less funding remains available for other providers, including hospitals. Further, since Medicaid payments account for about 68 percent of nursing home revenues, there is little opportunity for those facilities to shift costs to other patients.

Medical assistance payments to hospitals statewide cover an average of 73 percent of the costs of treating Medicaid and SAGA clients. Only Bradley Memorial Hospital (which is no longer a separate hospital) is funded fully for its Medicaid costs. State Medicaid payments account for about 10 percent of all hospital revenues, and historically hospitals were able to shift the gap from government underpayments onto private payers. But Medicaid clients make up about 17 percent of all inpatient discharges, and for some hospitals, with shrinking private paying populations, there is nowhere to shift costs.

Over the past decade, federal provisions to balance the nation's budget have had a negative impact on most hospitals in Connecticut and the Northeast. For example, the Balanced Budget Act of 1997 required Medicare to readjust its rate structure to pay more to hospitals in rural areas of the country while remaining budget neutral.

Connecticut's Health Insurance and Hospital Market

In addition to these elements, there has been a convergence of other factors that have shaken the financial footing of some state hospitals. A major component is an imbalanced health care insurance and hospital industry, with market share heavily concentrated in a few insurers and hospitals.

There has been considerable consolidation in the health insurance industry in Connecticut. In 1995, there were 12 licensed health maintenance organizations (HMOs), and five of them were non-profits. Currently there are six licensed HMOs and all are for-profit. While there are also approximately 20 other health insurers, the health care insurance market is dominated by a few insurers. In fact, one company has 43 percent of individuals covered by private health insurance in Connecticut.

These private health insurers negotiate with individual hospitals on what the insurance companies will pay them for services. Connecticut had an all-payer rate-setting system for hospitals until 1994. Under that structure, all hospitals were almost assured their costs would be covered by the various government and private payers. Since hospital rate deregulation, there has been a competitive market for private payers, while government programs like Medicare and Medicaid set rates that hospitals must accept.

After hospital rate deregulation, there were four hospital closings in Connecticut – St. Joseph's in Stamford, Mt. Sinai in Hartford, Park City in Bridgeport, and Winsted Hospital in Winsted. In FY 92, before these closings, Connecticut had 9,437 hospital beds[11]; in FY 05 there were 7,223 hospital beds, a reduction of 23 percent. However, the occupancy rate of the staffed beds has not changed significantly – it was 73.3 percent in FY 92 and 77.3 percent in FY 05 reflecting an increasing shift from inpatient stays to outpatient treatment and services, as well as decreasing length of inpatient stays over the 1990s and early half of this decade.

Competition among hospitals. Since the hospital closings and bed reductions, it appears that Connecticut does not have excess hospital capacity. Connecticut has a lower number of hospitals and hospital beds per capita than most other states. But because the state is small and densely populated, Connecticut residents have a hospital located closer to them than residents have in almost any other state. However, not all hospitals provide the same services or have the same type of staffed beds. Residents may seek treatment at their local community hospital in an emergency, or if they have pneumonia, because it is close and convenient. However, for a more complicated procedure, residents have the option of obtaining services at a larger urban hospital not that far away.

The committee met with representatives of Connecticut health maintenance organizations to discuss the study and hospital funding issues. HMO representatives indicate that Connecticut consumers want to have their local hospital covered in the health care plan their employer chooses. But that means one of the tenets of managed care – to limit the providers in a network to those willing to accept the insurer's price, in exchange for assured volume – has not been implemented successfully. Conversely, because of the consolidation in the health insurance market, smaller hospitals have to be included in the remaining large health plans to be assured any private pay patients, but do not have much bargaining leverage on price, and have little guarantee of patient volume from the insurer.

The hospital market in Connecticut is also highly concentrated. Four hospitals have more than one-third of the staffed bed capacity in the state:

Yale-New Haven – 10.2 percent	**Hartford – 9.4 percent**
St Francis – 7.4 percent	**St. Raphael – 5.8 percent**

The same four hospitals accounted for 37 percent of all inpatient days and 35 percent of all equivalent patient days (a calculation that accounts for both inpatient and outpatient services) for FY 05. The next four hospitals –Danbury, Bridgeport, Lawrence and Memorial, and St. Vincent's -- account for another 20 percent of volume, which means that eight hospitals (25.8 percent of the 31 hospitals) account for 55 percent of the hospital business in Connecticut. On the other end of the spectrum, five hospitals – Bradley, Johnson, New Milford, Rockville and Sharon – each accounted for less than one percent of all inpatient discharges.

[11] LPR&IC, *Health Care Cost Containment in Connecticut*, February 1994

The measure for outpatient days (equivalent patient minus inpatient days) is somewhat more evenly distributed. The top six hospitals account for almost 38 percent of outpatient days. Three of the four hospitals – Yale- New Haven, Hartford, and St. Francis -- that have a greater market share of beds and inpatient days also account for the highest percentage of outpatient days. St. Raphael is not among the top six hospitals, and accounts for less than four percent of outpatient days.

Thus, health care is considered to be a "competitive" market in that prices are not set by the state for private payers. But consolidation of health plans and the dominance of the hospital market in Connecticut by several larger hospitals create an uncompetitive health care system.

While health care prices and costs are not regulated by the state, the services a hospital offers are, to some extent, controlled through the certificate of need (CON) process. The CON is a regulatory provision that attempts to hold down costs by limiting the number of health care facilities in the state that can provide a new, upgraded, or expanded service. Thus, many of the larger hospitals have services (and physicians to perform them) approved through the CON process, that smaller community hospitals do not.

The certificate of need process for medical services largely applied to hospitals, and until July of this year, included capital expenditures or expansions of more than $1 million dollars, and major medical equipment that would have cost more than $400,000. Legislation passed during 2006 increased the CON thresholds for both capital expansions and major medical equipment to $3 million. However, CON rules on imaging equipment were tightened so that most types have to be approved by CON no matter how they are acquired, or how little the cost.

Connecticut average hospital costs are still higher than in most states. As reported in the briefing, FY 04 hospital inpatient expenses were about 15 percent higher in Connecticut than nationally. However, there is wide variation among hospital costs in Connecticut. Using a broad cost measure -- expense per case mix adjusted equivalent discharge (CMAED) – which accounts for case mix acuity and both inpatient and outpatient business, program review found that the average CMAED expense was $7,054. However, the standard deviation (distance from the average) was $1,572 and the range was a low of $3,904 at Johnson Memorial, to a high of $11,867 at CCMC. Much of the variation in costs can be attributed to location, especially for those hospitals in Fairfield County where wages are especially high, and to the added expense in teaching hospitals.

Historically, most consumers have not paid for health care directly, but through an insurer or other third party. Therefore, insured individuals have not been that concerned about costs, and so hospitals and other providers have not had to compete on price. This is changing, as consumers are increasingly asked to shoulder a greater share of their health care premiums, and also incur higher deductibles and co-pays.

The current federal administration and Congress have promoted this paradigm shift to greater individual responsibility for financing health care, by enacting tax incentives for health savings accounts and other consumer-directed ways to pay for health care. The belief is that only if consumers have "skin in the game" will they care about health care costs. However, the

ultimate success of increased consumer involvement and its impact on health care providers and hospitals is difficult to predict.

Other Competitive Pressures

Fixed costs. Because hospitals are typically large institutions operating 24 hours a day, seven days a week, their fixed costs are high. Hospitals must pay for round-the-clock staffing, and compete with each other as well as with other health care providers for nurses, nursing assistants, and other medical personnel. Hospitals also face increasing energy costs and high medical malpractice insurance premiums.

Hours of operation. Hospital emergency rooms are always open, and there is a growing trend in emergency room use as shown in Chapter III. Whether the visit is prompted by a true emergency, limited access to other primary care, the time of day that care is needed, or physician advice to go to the ER, the reasons are secondary to the fact there is a community expectation to receive medical treatment at a hospital any time. Twenty-four hour emergency room care is a costly and unpredictable service that only hospitals are providing. Even the FQHCs, which receive much of their funding from Medicaid and other government sources, and whose major purpose is to provide primary and preventive care to Medicaid and other low-income residents, operate on a much more limited schedule.

Other health care facilities. Hospitals have been subject to the CON process since the late 1970s. However, since 2004 outpatient or ambulatory surgical centers (ASCs) are also subject to the CON process, with certain exceptions, including if the facility was in operation prior to July 1, 2003. As of June 2006, there were 33 outpatient surgical centers licensed by the state Department of Public Health. By March 30, 2007, all surgical centers will have to be licensed by DPH, but will not have to meet accreditation requirements, such as the Joint Commission on Accreditation of Hospitals (JCAHO) standards.

Ambulatory surgical centers now perform many of the procedures that used to be carried out in hospitals. According to hospital administrators, that has taken many of the private pay patients away, and left the sicker and/or Medicaid or Medicare patients for the hospitals to serve. This also contributes to the poor financial condition of some hospitals.

Currently, the state does not collect data to assess what type of procedures or how many are being conducted in ambulatory surgical centers. A recent American Hospital Association issue brief indicates that most are in the areas of ophthalmology, orthopedics, gastroenterology, and gynecology, and that the volume of these procedures for Medicare beneficiaries rose 145 percent between 1997 and 2004.

Many of the ASCs have some or all physician ownership, so there is a financial incentive for doctors to refer and perform more procedures at these locations. While initially it was projected these ASCs would lower health care costs by dropping the expense per procedure, Medicare and other major payers are now concerned that, because of increased volume of procedures at these facilities, it has contributed greatly to increasing costs overall.

Another aspect of the regulatory imbalance is that hospitals must report their financial and utilization data to the Office of Health Care Access, while other health care providers currently do not. Since 1998, OHCA statutorily has had the option to collect "patient level" outpatient data from ambulatory surgical centers and other health care providers (as defined in C.G.S. Sec. 19a-630). However, although the agency is developing regulations for this reporting, it does not appear that financial data will be required. The lack of system-wide health care data makes it difficult to evaluate consumer access, financial impact, and outcomes for many health care services.

Hospitals are required to report a great deal of financial and expense data to the Office of Health Care Access. Not required to be reported, however, is the expense for marketing a hospital or a particular service a hospital provides. While the actual dollars spent on marketing may not be that great, many policymakers believe that marketing in health care – whether for prescription drugs or elective medical procedures – create demand, which further increases costs.

Summary of Findings:

Connecticut hospitals are not all similar or equal entities. Hospitals vary by location populations they serve, as well as by size and services offered. They are not all structured similarly, nor do they have equal bargaining power to negotiate with health insurers or compete for privately insured patients. A combination of these historical, regulatory, and market forces have shaken the financial foundation of many.

There is a community expectation that local hospitals will be there for emergency care and basic medical treatment 24 hours a day, but it is clear that for elective procedures or more specialized medical services, patients are going elsewhere. In many cases, the smaller urban and community hospitals have the lowest expenses, but state government cannot mandate where people should go to receive their medical service, and increasingly it is apparent that managed care has not been successful in that either.

Without private paying patients obtaining services at hospitals, it is likely that not all hospitals will survive as currently structured. Recent developments that have indicated that include:

- *Essent Healthcare Corporation, a private for-profit company, purchased Sharon Hospital in 2002. Essent/Sharon, which was previously a non-profit, now operates as a for-profit hospital. That hospital has also received Medicare designation as a sole community provider hospital, which gives it a higher Medicare rate, and has helped improve the hospital's condition dramatically.*

- *Since October 1, 2006 Bradley Memorial and New Britain General Hospitals consolidated, although both campuses are still operating.*

Although recommendations are made to change the Medicaid fee-for-service payment structure, and increase accountability of Medicaid managed care organizations, Medicaid payments are not a large source of most hospitals' revenue stream. For the smallest hospitals,

serving less than one percent of all patients statewide, and a very small portion of Medicaid clients, the payment changes from Medicaid will not help their financial situation.

Market forces -- whether inability to compete for scarce nursing and other medical personnel to staff hospitals, or failure to attract enough paying patients to cover hospital expenses – may result in further consolidations or closures. Hospital consolidation or closure may not bring about lower hospital costs, but only shift utilization to the remaining higher cost hospitals. It is difficult to predict what factors individual consumers will consider when making more of their own health care decisions and what impact that will have on individual hospitals.

While steps have been taken to level the regulatory playing field between hospitals and other health care facilities, further efforts are needed. In addition, consumers will need better information on all aspects of their health care, if they are expected to shoulder more of the cost burden and make informed choices. To advance these areas, the committee recommends the following:

The Office of Health Care Access should broaden its oversight perspective to include requiring reporting of outpatient data from health care facilities as outlined in statute. OHCA should analyze and report on outpatient data as they do inpatient hospital data. The office should also phase in a reporting requirement of aggregate financial data from health care facilities other than hospitals.

The Office of Health Care Access shall report on indicators of hospital expenses as part of its *Annual Report on the Financial Status of Connecticut's Hospitals.* Those indicators for each hospital should include but not be limited to:

- **the expense per case mix adjusted discharge and equivalent discharge,**
- **salary and fringe benefit expenses for the top ten positions as reported on Attachment 25 from hospitals; and**
- **administrative expenses related to marketing.**

Statutorily, the Office of Health Care Access may establish a consumer education unit "to provide information to residents of the state concerning the availability of public and private health care coverage", but OHCA indicates the unit is not currently operational. **The committee recommends that OHCA, within available staffing resources, develop and disseminate through its website, information that will assist consumers in making more informed health care decisions. Such information should be developed in concert with the Department of Insurance, where appropriate, and should include, but not be limited to:**

- **managed care report card results reported by the insurance department;**
- **information on average, median, and range of premiums charged by Connecticut- licensed health insurers;**

- **medical loss ratios of health insurers, and to the extent possible, their profit margins;**

- **the hospital expense data reported on an individual basis (as recommended above);**

- **hospital performance ratings as measured in the National Healthcare Quality Report, which includes hospital grades based on a series of measures used by CMS under Medicare as well as other quality indicators;**

- **rating outcomes for Connecticut hospitals based on about two dozen common hospital procedures currently evaluated by Health Grades, Inc. (see rationale below); and**

- **OHCA's estimates of what the hospital's charges and costs for the procedure would be, using patient data OHCA obtains from hospitals and CHIME data, matched with outcome ratings.**

OHCA should begin to develop and report similar information for other health care facilities and providers as the data are obtained.

Rationale

The recommendation to expand OHCA's collection and reporting of data from health care facilities, in addition to hospitals, recognizes that much current medical care is provided outside a hospital setting. Connecticut's reporting requirements should not apply to only one area of the health care system.

In addition to the cost data currently included in OHCA's annual hospital report, the committee believes that an expense factor per patient should be included. If a hospital's expenses are reported on an individual patient level, it makes financial data more understandable, easier to compare, and ultimately more usable by both policymakers and consumers.

The hospital expense reporting requirement should be a first step in providing comparable data consumers can understand and use. But as consumers need both evaluative and financial information to make health care decisions, OHCA and CID will have to assist. The recommendation is a starting point for offering information in one place regarding health insurance, and hospital evaluations and outcomes.

The CMS and the National Healthcare Quality Report data are readily available. They can be used to compare grades among hospitals within a state, and to compare a state's overall hospital performance with that in other states. The use of the Health Grades information on hospital procedures is currently publicly available at no charge. Health Grades is a publicly traded health care ratings company. The company uses Medicare data available through CMS and uses the APR-DRG grouper (discussed in Chapter I) to evaluate and assign one of three ratings to a hospital based on actual outcomes -- either based on short and long-term survival, or complications, depending on the procedure -- versus what might be predicted given the patient

characteristics having the procedure. The committee recommends that OHCA supplement the information with relevant hospital financial data, starting with the same specific procedures, which would give the consumer a more complete picture on which to make decisions.

OHCA should also explore obtaining access to additional evaluative information for other procedures, and in other settings, either through Health Grades or other health care evaluation organizations. OHCA could also begin developing its own evaluation information -- for additional procedures and conditions, using hospital inpatient data it already obtains, and through use of new grouper systems available -- and produce and report on comparative outcomes results, together with financial information.

Containing Health Care Costs

Improving the Medicaid payment system to hospitals and strengthening hospital reporting and state agency oversight on their financial condition may help some hospitals in the short term. But as this report discusses, hospital care is only one part of the fragmented, partly regulated, partly competitive, multi-payer, costly health care system. Increasingly, economists and health care policy experts indicate that recent growth in health care costs is unsustainable, and that unless actions are taken to curb that growth, they predict dire consequences.

As evidence of the unsustainable growth, the literature points to the rise in health care costs as measured against several important economic indicators like growth in the gross state product, rises in personal income, and growth in health insurance premiums compared to wages. Program review examined many of these measures as they pertain to Connecticut's health care system and presents them in this section.

Health Care Spending Outpacing Other Economic Growth

Gross state product. As discussed in the briefing report, national health care expenditures[12] now consume approximately 16 percent of the gross domestic product (GDP), and personal health care expenditures nationwide account for about 14 percent of the GDP. In Connecticut, personal health care spending for 2004 was about 11.7 percent of gross state product, less than the national average. However, if the trends in growth are measured, health expenditures are growing faster than gross state product.

- From 1993 to 2004 gross state product increased by 60.3 percent while personal health care expenditures grew by 66 percent.
- The average annual increase in gross state product was 5.02 while health care expenditures grew at annual rate of 5.5 percent.

Health care spending increases of 5.5 percent also have exceeded yearly increases in Connecticut's state budget, which have averaged 4.8 percent since 1993. Further, 20 percent of the state's budget is Medicaid; if Medicaid were excluded from the budget, state expenditure

[12] National health care expenditures include personal health care expenses as well as spending on research and other grants made by government agencies such as National Institute of Health and Centers for Disease Control. Personal health expenditures exclude these costs.

growth would be less. Connecticut health care costs are far outpacing inflation. The annual increases in the consumer price index since 2005 have been about 2.6 percent or about half of the annual increases in health care expenditures.

On a more individual level, Connecticut has a high per capita income – measured at $47,819 in 2005, which is about 38 percent higher than the national average. But the annual growth rate in the state's per capita income over the past 10 years was 4.3 percent, lagging behind the 5.5 percent yearly increases in health care costs.

Recognizing that health care costs in the state are rising at an alarming rate is important in terms of the state's overall economy, because business decisions on whether to locate or expand in the state or not are impacted, as is a business's decision to continue to provide health insurance to its employees. Out-of-control health care costs stifle growth in other areas of the economy, leaving employers with less money to expand a company or increase wages. Individuals also feel the impact, with fewer dollars to spend on housing, utilities, education, or entertainment.

Private health insurance. As reported in the briefing, based on 2004 census data Connecticut has a higher percentage of state residents who are covered by employer-based health insurance and a lower percentage of uninsured than the rest of the country. However, the trends in Connecticut coverage are negative:

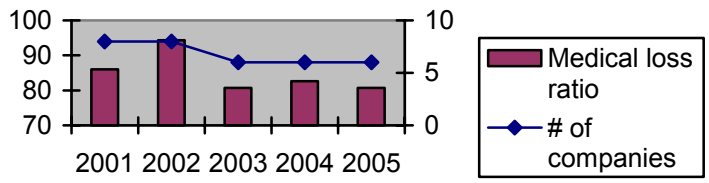
- The 2004 census data indicate that Connecticut's percentage of population covered by employer insurance has shrunk from 72.5 percent in 1999 to 67.2 percent in 2004.

- The 2004 census data showed that 407,000 people were uninsured, an increase of 50,000 people without insurance from 2003.

- The committee obtained 2006 health insurance coverage statistics from CID, which show a further net decline of privately insured people (73,200) since 2005. Further, the decline (79,282) is in the HMO coverage area, with more comprehensive benefits, while the indemnity plans (typically with high deductibles) showed an increase in coverage of almost 6,100.

The CID also provided the annual medical loss ratios (percent of revenue spent on medical expenses) for health insurers licensed in Connecticut from 2001 through 2005. The committee used the loss ratios for the licensed HMOs, and the average annual medical loss ratios (not weighted by size of premiums), and the results are shown in Figure IV-2. (Staff did not use the loss ratios of the indemnity health insurance companies; if those were included the average medical loss ratios would be less.)

Figure IV-2. Average Annual Medical Loss Ratios of CT HMOs -- 2001- 2005



Source: LPR&IC Staff Analysis

As the figure shows, except for 2002, when the average medical loss ratio was 94.3 percent, loss ratios have been well below 90 percent, and as the industry has consolidated, the ratios have been trending down towards 80 percent. The committee could not determine profit margins, but insurance department financial data show all Connecticut licensed health insurers had positive net income for each of the past three years.

A report released in October 2006 by Families USA, a national non-profit health care consumer group, indicates that "over the past six years (2000 to 2006), family health insurance premiums for Connecticut workers rose 5.8 times more quickly than median earnings. On average, family health care premiums rose by 77 percent [over the period] while median earnings rose only 13.2 percent."

- The average health insurance premium for family coverage in 2006 was $12,904 -- the employer share is $10,246 and the employee's share is $2,658.

- The most recent state comparative data for 2004 showed Connecticut's health insurance premiums were the fourth highest in the nation (including D.C., with the highest), and 10 percent more than the national average.

- A recent survey conducted by the Connecticut Business and Industry Association (CBIA) of its members (released in September 2006) indicates that for the fifth straight year, respondents stated that high health care costs are the major financial concern of businesses in Connecticut. Further, almost 60 percent of CBIA survey respondents said they had experienced increases of 10 percent or more in health care costs in the past year.

- Some of the higher health insurance premiums in Connecticut may be to cover the cost shift in hospital care for the uninsured and Medicaid and Medicare population, but it does not appear to be reflected in health insurers' medical loss ratios, which are declining.

The committee believes that the recent growth in health care costs is unsustainable and that it is beginning to affect private insurance coverage, both in the actual decline in numbers and the shift to less coverage. However, covering the uninsured in a government-insured program does not seem to be either an affordable, or a long-term, solution. Government insurance,

especially Medicaid, with lower reimbursement rates and limited community access, appears to increase hospital utilization. As this report has discussed, hospital emergency room use is highest among government payers, and inpatient care is also higher among the Medicaid and SAGA populations.

Coupling lower government reimbursement rates with increasing the numbers of a high-utilization population will only further worsen some hospitals' financial condition. Further increasing the amounts of underpayments will likely add to the portion private insurers are expected to pay, driving premiums higher while insuring fewer people. Instead, the committee believes the state must take steps to make private health insurance more affordable and improve access to primary and preventive care.

The factors contributing to higher health care costs in Connecticut that need closer examination are numerous, interconnected, and complicated. While this report has discussed many elements -- from Connecticut's high portion of costs for nursing home care to the added costs of teaching hospitals -- many are beyond the scope and resources of this study.

The Office of Health Care Access already has statutory responsibility to "oversee and coordinate health system planning; and monitor health care costs" (C.G.S. Sec. 19a-613 (3)(b). but the committee believes the responsibility for containing health care costs is beyond the scope of one state agency.

Recognizing the breadth and severity of the problem, the committee recommends that a panel should be established and convened by March 1, 2007, to examine health care costs, make private health insurance more affordable, and improve access to primary and preventive health care.

The panel should consist of the following 40 members:

Six members of whom one each shall be appointed by the speaker of the House of Representatives, the president pro tempore of the Senate, the majority leader of the House of Representatives, the majority leader of the Senate, the minority leader of the House of Representatives, and the minority leader of the Senate;

The chairpersons and ranking members of the committees on: public health; insurance; human services; commerce; appropriations; finance, revenue and bonding;

Ten members appointed by the Governor, who shall include representatives from the Connecticut Hospital Association, the Connecticut Business and Industry Association, Connecticut Medical Society, the Connecticut Nurses' Association, Connecticut Primary Care Association, the state association representing health care plans, and the Connecticut Association of Health Care Facilities; and

The commissioners, or their designees, of the Office of Policy and Management, the Office of Health Care Access, Connecticut Insurance Department, Department of Public Health, Department of Social Services, Department of Mental Health and Addiction Services;

The panel shall be convened by the chairs of the legislature's public health and insurance committees and the panel shall elect its co-chairs from among its members.

Areas for the panel's consideration should include but not be limited to:

- ***The state's current nursing shortage*** **and developing strategies for enhancing the education and supply of nurses. The panel should consult the report issued in October 2005 by the Council of Deans and Directors of Nursing Programs.**

- ***Strategies to promote increased access to primary and preventive care, especially for Medicaid populations, which should include expanding hours of federally qualified health care clinics.*** *(In October 2006, approximately $14 million in state bonding money was approved to expand and improve the facilities of several FQHCs)*

- ***Encouraging development and approval of health insurance products*** **that lower costs to consumers if they maintain healthy lifestyles. For example, new policies provide discounts for persons who maintain a body mass index below a certain level. Also, current health care policies seem to emphasize high consumer deductibles and co-pays at the front end, but once the deductible level is reached, the consumer has no financial incentive to consider cost in the health care decision. Perhaps policies could combine lower initial deductibles, with a percentage of overall costs for a consultation, procedure, or diagnostic test borne by the consumer. The consumer would then have a financial interest in knowing and comparing costs.**

- ***The adequacy of the current level of regulation by the Insurance Department over health insurers and premium rate increases.***

- ***Current statutory health insurance mandates*** **and analysis of whether they add to health care costs in Connecticut.**

- ***Strategies to assist lower-wage individuals and small businesses pay health insurance premiums.***

- ***The current distribution of state Medicaid dollars*** **-- specifically the high proportion to nursing homes.**

The panel should report its findings and recommendations to the Governor and Legislative leadership by January 1, 2008.

The committee is aware of the great interest by state lawmakers to address health care cost and access issues, both in terms of funding and service delivery, as soon as possible. Indeed, in the context of hospitals as they currently exist now in Connecticut, and in terms of cost areas over which the state currently has some control, the proposed recommendations

contained in this report are intended to promote access and cost accountabilities. There may be other recommendations affecting other parts of the health care system that could be implemented in the near future also. However, longer-term solutions to the access and cost problems might well require fundamental change. While some might say more study at this point is avoiding the issues, the committee thinks that the situation may be serious enough now, and recognized as such, that a time-limited, well-focused, purposeful, and inclusive system-wide review would be beneficial.

APPENDIX A. Comparison of Medicaid Payments Under Current Reimbursement System and New Reimbursement System.								
HOSPITAL	Proposed Reimbursement System				2005 Medicaid Discharges	New Payments= (New Weighted Rate * Discharges)	Current Medicaid Payments	Difference b/w New Payments and Current Payments
	06 Current Medicare Base Rate	New Rate = Current Base Rate + ($ IME * % of Inpatient Medicaid)	Medicaid Case Mix Index	New Weighted Rate = (New Rate * Medicaid Case Mix Index)				
Backus	$5,301	5301.00	0.88	4,664.88	1682	$7,846,328	$5,587,224	$2,259,104
Bradley	$5,301	5301.00	1.05	5,566.05	66	$367,359	$203,094	$164,265
Bridgeport	$5,785	6003.97	0.92	5,523.65	4767	$26,331,256	$19,862,511	$6,468,745
Bristol	$5,301	5301.00	0.78	4,134.78	1181	$4,883,175	$3,589,427	$1,293,748
CCMC	$5,301	5757.65	1.24	7,139.48	2368	$16,906,297	$25,187,188	-($8,280,891)
Danbury	$5,785	5860.15	0.75	4,395.11	2378	$10,451,571	$9,016,193	$1,435,378
Day Kimball	$5,301	5301.00	0.64	3,392.64	1102	$3,738,689	$3,893,196	-($154,507)
Greenwich	$5,785	5793.57	1.00	5,793.57	276	$1,599,024	$1,933,185	-($334,161)
Griffin	$5,635	5715.18	0.67	3,829.17	1094	$4,189,116	$3,642,437	$546,679
Hartford	$5,301	5474.52	1.05	5,748.25	6540	$37,593,543	$36,524,518	$1,069,025
Hungerford	$5,301	5301.00	0.74	3,922.74	995	$3,903,126	$1,876,762	$2,026,364
John Dempsey	$5,692	6151.65	1.24	7,628.05	1466	$11,182,716	$20,613,055	-($9,430,339)
Johnson Memorial	$5,301	5301.00	0.73	3,869.73	462	$1,787,815	$2,190,496	-($402,681)
Lawrence Memorial	$5,301	5303.02	0.80	4,242.41	2329	$9,880,578	$7,996,976	$1,883,602
Manchester	$5,301	5301.00	0.75	3,975.75	1122	$4,460,792	$3,544,238	$916,554
Middlesex	$5,325	5360.12	0.80	4,288.10	1309	$5,613,117	$4,632,485	$980,632
MidState	$5,635	5635.00	0.82	4,620.70	1476	$6,820,153	$4,971,477	$1,848,676
Milford	$5,635	5635.00	0.76	4,282.60	337	$1,443,236	$1,230,090	$213,146
New Britain	$5,301	5391.45	0.79	4,259.24	3433	$14,621,977	$11,452,067	$3,169,910
New Milford	$5,785	5785.00	0.81	4,685.85	232	$1,087,117	$727,621	$359,496
Norwalk	$5,785	5838.76	0.81	4,729.40	1398	$6,611,695	$10,227,178	-($3,615,483)
Rockville	$5,301	5301.00	0.69	3,657.69	590	$2,158,037	$1,828,516	$329,521
Sharon	$5,301	5301.00	0.85	4,505.85	293	$1,320,214	$1,075,495	$244,719
St. Francis	$5,301	5459.44	0.93	5,077.28	6410	$32,545,381	$26,292,191	$6,253,190
St. Mary's	$5,635	5763.75	0.83	4,783.91	2524	$12,074,599	$6,842,636	$5,231,963
St. Raphael	$5,635	5748.71	1.01	5,806.20	3062	$17,778,587	$17,622,266	$156,321
St. Vincent's	$5,785	5867.49	0.93	5,456.77	2816	$15,366,252	$12,651,702	$2,714,550
Stamford	$5,785	5878.75	0.80	4,703.00	2805	$13,191,919	$10,179,648	$3,012,271
Waterbury	$5,635	5749.00	0.79	4,541.71	3108	$14,115,623	$11,060,318	$3,055,305
Windham	$5,301	5301.00	0.88	4,664.88	851	$3,969,813	$3,536,556	$433,257
Yale-New Haven	$5,635	6241.96	1.00	6,241.96	11,669	$72,837,431	$65,837,444	$6,999,987
TOTAL						$366,676,538	$335,828,190	**$30,848,348**

APPENDIX B. DSS Calculation of 2006 Medicaid DSH Adjustment.			
Hospital	**Total Inpatient Medicaid Days (Fee for Service + Medicaid Managed Care)**	**Total Days**	**Utilization Rate**
Backus	5,799	46,215	12.5479
Bradley	226	10,591	2.1339
Bridgeport	21,638	107,649	***20.1005**
Bristol	3,473	36,280	9.5728
Danbury	7,282	78,729	9.2495
Day Kimball	3,301	22,709	14.5361
Dempsey	12,476	57,940	***21.5326**
Essent/Sharon	306	12,671	2.4150
Greenwich	929	47,534	1.9544
Griffin	4,406	32,304	13.6392
Hartford	33,544	219,452	15.2853
Hungerford	3,436	28,350	12.1199
Johnson Memorial	2,113	19,052	11.0907
Lawrence Memorial	7,001	68,083	10.2830
Manchester	3,950	40,812	9.6785
Mid State	4,468	41,260	10.8289
Middlesex	4,599	49,709	9.2518
Milford	1,205	22,611	5.3293
New Britain General	10,992	68,122	16.1358
New Milford	733	14,352	5.1073
Norwalk	7,370	81,123	9.0850
Rockville	1,928	16,097	11.9774
St. Francis	27,739	163,640	16.9512
St. Mary's	8,846	54,510	16.2282
St. Raphael	19,083	142,069	13.4322
St. Vincent's	12,153	99,386	12.2281
Stamford	8,428	77,981	10.8078
Waterbury	10,832	68,955	15.7088
Windham	3,315	21,127	15.6908
Yale-New Haven	54,304	219,217	***24.7718**
		Standard Deviation	5.4216
		(Average) Mean	11.9891
		Qualifying Level	*17.4107
Source: Department of Social Services			

APPENDIX C. Total Uncompensated Care (FYs 03-05)				
HOSPITAL	FY 03 Uncompensated Care	FY 04 Uncompensated Care	FY 05 Uncompensated Care	% Change FYs 03-05
CCMC	$3,644,349	$2,171,171	$2,445,934	(33)
Dempsey	$4,272,895	$4,185,950	$3,476,379	(19)
Windham	$5,432,116	$5,155,032	$4,990,522	(8)
Lawrence Memorial	$13,347,968	$12,874,803	$13,395,464	0
St. Raphael	$18,083,726	$17,663,866	$18,199,402	1
Hungerford	$1,894,826	$2,278,201	$1,947,497	3
Essent/Sharon	$2,295,048	$2,410,228	$2,419,280	5
Manchester	$5,152,707	$5,413,279	$5,451,532	6
Yale-New Haven	$32,253,433	$33,664,340	$36,964,963	15
Milford	$2,801,121	$3,683,683	$3,241,441	16
St. Vincent's	$17,156,028	$19,059,573	$19,866,424	16
Backus	$8,239,313	$10,977,791	$10,011,674	22
Bristol	$6,233,713	$7,122,372	$7,584,934	22
Mid State	$6,520,245	$6,807,303	$7,998,165	23
Johnson Memorial	$3,866,601	$4,704,822	$4,848,034	25
Day Kimball	$3,477,747	$3,132,414	$4,423,014	27
Middlesex	$9,903,749	$14,498,715	$12,614,782	27
Hartford	$31,856,407	$36,657,229	$41,985,236	32
Waterbury	$10,473,974	$14,339,518	$14,068,249	34
Greenwich	$12,306,998	$16,053,277	$16,553,803	35
Danbury	$14,271,520	$17,237,050	$19,468,850	36
Stamford	$24,624,041	$30,032,611	$35,442,287	44
Norwalk	$10,907,959	$14,885,278	$15,763,727	45
Rockville	$2,084,207	$2,453,416	$3,014,577	45
St. Mary's	$6,454,340	$8,135,112	$9,845,637	53
St. Francis	$12,736,606	$18,084,399	$19,654,497	54
Bridgeport	$17,570,047	$21,719,413	$27,409,489	56
Griffin	$4,525,854	$8,449,356	$8,509,881	88
New Britain General	$6,217,635	$10,136,906	$12,362,379	99
New Milford	$1,490,032	$1,852,956	$3,269,087	119
Bradley	$338,127	$1,713,647	$910,635	169
TOTAL	**$300,433,332**	**$357,553,711**	**$388,137,775**	**29%**
Source of Data: OHCA Schedule 202				

APPENDIX C-1. Total Free Care (FYs 03-05)				
HOSPITAL	FY 03 Free Care	FY 04 Free Care	FY 05 Free Care	% Change FYs 03-05
Bristol	$732,469	$816,487	$688,672	(6)
St. Mary's	$1,050,982	$890,352	$1,175,197	12
Lawrence Memorial	$1,552,625	$1,188,480	$1,898,766	22
St. Raphael	$3,024,726	$4,363,864	$3,901,407	29
Greenwich	$8,307,388	$12,463,363	$11,932,073	44
Waterbury	$1,097,262	$1,377,666	$1,620,443	48
Johnson Memorial	$273,603	$183,885	$431,525	58
Stamford	$4,110,096	$5,691,530	$6,566,676	60
Yale-New Haven	$7,780,683	$11,977,918	$12,560,367	61
Windham	$923,778	$1,525,814	$1,625,369	76
Hartford	$9,633,009	$13,804,234	$17,123,304	78
Bradley	$16,864	$15,593	$32,174	91
Norwalk	$2,674,891	$3,743,284	$5,122,306	91
Mid State	$472,777	$573,899	$917,479	94
Danbury	$4,078,391	$6,205,087	$8,121,149	99
CCMC	$202,553	$248,655	$420,544	108
St. Vincent's	$2,066,171	$3,029,728	$5,231,883	153
Middlesex	$884,788	$1,294,206	$2,253,481	155
Manchester	$458,636	$1,495,089	$1,281,564	179
Day Kimball	$268,687	$313,884	$759,601	183
Hungerford	$197,281	$461,199	$566,431	187
Bridgeport	$3,079,342	$5,637,217	$8,920,434	190
Essent/Sharon	$190,132	$314,346	$600,122	216
Rockville	$193,609	$705,733	$715,770	270
Backus	$621,678	$1,703,843	$2,535,009	308
Milford	$63,667	$115,089	$371,489	483
St. Francis	$1,087,791	$4,490,813	$7,030,166	546
Dempsey	$103,943	$806,223	$752,944	624
Griffin	$170,529	$439,853	$2,094,321	1128
New Britain General	$25,846	$0	$327,997	1169
New Milford	$70,521	$419,455	$1,173,949	1565
TOTAL	**$55,414,718**	**$86,296,789**	**$108,752,612**	**96%**
Source of Data: OHCA Schedule 202				

APPENDIX C-2. Total Bad Debt (FYs 03-05)				
HOSPITAL	FY 03 Bad Debt	FY 04 Bad Debt	FY 05 Bad Debt	% Change FYs 03-05
CCMC	$3,441,796	$1,922,516	$2,025,390	(41)
Dempsey	$4,168,952	$3,379,727	$2,723,435	(35)
Windham	$4,508,338	$3,629,218	$3,365,153	(25)
Hungerford	$1,697,545	$1,817,002	$1,381,066	(19)
Essent/Sharon	$2,104,916	$2,095,882	$1,819,158	(14)
Manchester	$4,694,071	$3,918,190	$4,169,968	(11)
St. Raphael	$15,059,000	$13,300,002	$14,297,995	(5)
St. Vincent's	$15,089,857	$16,029,845	$14,634,541	(3)
Lawrence Memorial	$11,795,343	$11,686,323	$11,496,698	(3)
Backus	$7,617,635	$9,273,948	$7,476,665	(2)
Yale-New Haven	$24,472,750	$21,686,422	$24,404,596	(0)
Milford	$2,737,454	$3,568,594	$2,869,952	5
St. Francis	$11,648,815	$13,593,586	$12,624,331	8
Danbury	$10,193,129	$11,031,963	$11,347,701	11
Hartford	$22,223,398	$22,852,995	$24,861,932	12
Day Kimball	$3,209,060	$2,818,530	$3,663,413	14
Middlesex	$9,018,961	$13,204,509	$10,361,301	15
Greenwich	$3,999,610	$3,589,914	$4,621,730	16
Mid State	$6,047,468	$6,233,404	$7,080,686	17
Rockville	$1,890,598	$1,747,683	$2,298,807	22
Johnson Memorial	$3,592,998	$4,520,937	$4,416,509	23
Bristol	$5,501,244	$6,305,885	$6,896,262	25
Bridgeport	$14,490,705	$16,082,196	$18,489,055	28
Norwalk	$8,233,068	$11,141,994	$10,641,421	29
Waterbury	$9,376,712	$12,961,852	$12,447,806	33
Stamford	$20,513,945	$24,341,081	$28,875,611	41
Griffin	$4,355,325	$8,009,503	$6,415,560	47
New Milford	$1,419,511	$1,433,501	$2,095,138	48
St. Mary's	$5,403,358	$7,244,760	$8,670,440	60
New Britain General	$6,191,789	$10,136,906	$12,034,382	94
Bradley	$321,263	$1,698,054	$878,461	173
TOTAL	**$245,018,614**	**$271,256,922**	**$279,385,163**	**14%**
Source of Data: OHCA Schedule 202				